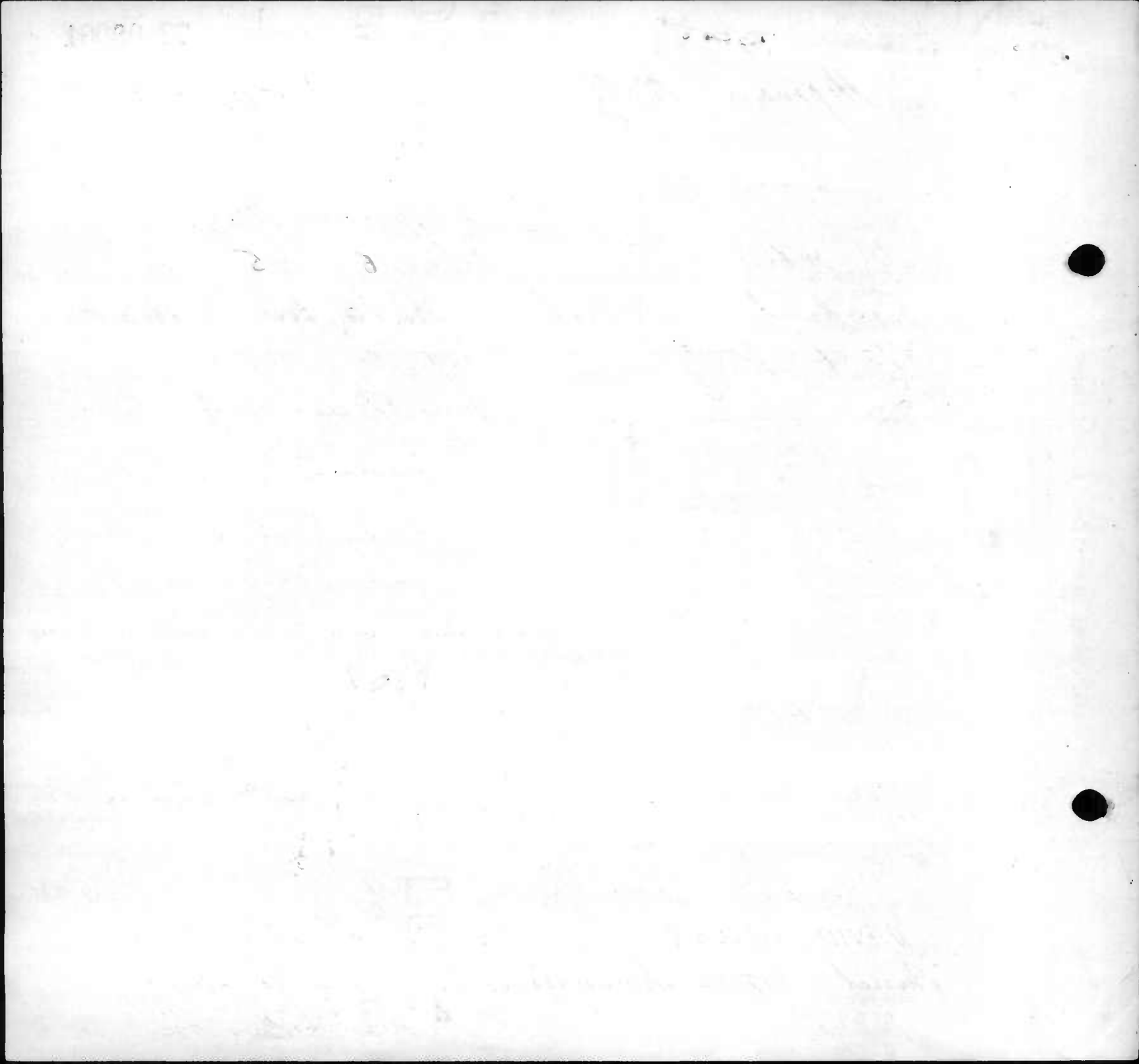


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 72 09001	
K-320 72 09001				STATE OF MARYLAND - BALTO	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Hyman Katz</i>			
2. DATE AND HOUR OF DEATH <i>Fri Sept 15/72 3:15 P.</i>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>42 Sinai Hosp</i>			
A. STATE <i>MD</i>		B. COUNTY <i>BALTO</i>		C. CITY OR TOWN <i>Balto</i>	
D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		E. STREET AND NUMBER <i>24 Wooded Way</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 2, 1915</i>	9. AGE (In years last birthday) <i>55</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>merchant</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Retail</i>		11. BIRTHPLACE (State or foreign country) <i>Balto, Md</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Max Katz</i>			
14. MOTHER'S MAIDEN NAME <i>Yetta Foy</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or date of service) <i>No</i>			
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs Theres Katz-Sance</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>Carcinoma of Kidney with Metastases</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Days</i>			
(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Bladder</i>			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Renal Failure</i>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(C) <i>Drug Reaction</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<i>Toxic Epidermal Necrolysis (Ampicillin)</i>			
19A. DATE OF OPERATION <i>None</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>None</i>		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Hospital</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>Sinai Hospital</i>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <i>8-31-72</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>Allergy to Ampicillin</i>	
22. I certify that (I) (this hospital) attended the deceased from <i>Aug 1972</i> to <i>Sept 15 1972</i> , that (I) (we) last saw the deceased alive on <i>Sept 15 1972</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>David R. Miller M.D.</i>				23B. DATE SIGNED <i>Sept 16 1972</i>	
23C. PHYSICIAN'S NAME (Type) <i>DAVID MILLER</i>				23D. ADDRESS <i>9115 Reisterstown Rd.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/19/72</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Swedish Kolonia</i>	
24D. LOCATION (City, town, or county) (State) <i>Balto Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>SEP 20 1972</i>			
25B. NAME OF REGISTRAR <i>Anthony Johnson</i>		25C. FUNERAL DIRECTOR <i>6010 Reister, Rd. Sol Severino Bros Inc</i>			





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-160		72 09002		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09002	
BIRTH NO.		72 09002		CERTIFICATE OF DEATH		STATE OF MARYLAND-DEATH	
1. NAME OF DECEASED (Type or Print) <i>Sidney J. Shapiro</i>				2. DATE AND HOUR OF DEATH <i>9/15/72</i> <i>3:30</i> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Baltimore City Hospitals</i>				A. STATE <i>Maryland</i> , B. COUNTY <i>Baltimore</i>			
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <i>4940 Eastern Avenue</i>				C. CITY OR TOWN <i>Pikesville</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Baltimore, Maryland 21224				E. STREET AND NUMBER <i>4 Applegate Court</i>			
5. SEX <i>Male</i>		6. RACE <i>White</i> <i>Caucasian</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>9/12/15</i>	
9. AGE (In years last birthday) <i>57</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Broker</i>		11. BIRTHPLACE (State or foreign country) <i>Brooklyn, New York</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Benjamin Benjamin Shapiro</i>				14. MOTHER'S MAIDEN NAME <i>Minnie ?</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes</i> <i>W.W.II</i>				16. SOCIAL SECURITY NO. <i>050-10-2328</i>		17. INFORMANT <i>Records: BCH-4940 Eastern Ave., 21224</i>	
18. <i>205.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Acute Myelogenous Leukemia</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR			
22. I certify that (I) (this hospital) attended the deceased from <i>8/21</i> 19 <i>72</i> to <i>9/15</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>9/15</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Roland C. Einhorn, MD</i>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>9/15/72</i>	
23C. PHYSICIAN'S NAME (Type) <i>Roland C. Einhorn, MD</i>				23D. ADDRESS <i>Baltimore City Hospitals</i> <i>4940 Eastern Avenue, Baltimore, Md. 21224</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9/17/1972</i>		24C. NAME of CEMETERY or CREMATORY <i>Baltimore Hebrew</i>		24D. LOCATION (City, town, or county) (State) <i>Reisterstown, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 20 1972</i>		25B. NAME OF REGISTRAR <i>Arday...</i>		25C. FUNERAL DIRECTOR <i>Sol Levinson &amp; Bros.</i>		ADDRESS <i>6010 Reisterstown Rd.</i>	

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M-620

72 C9003

STATE OF MARYLAND  
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 C9003

BIRTH NO.

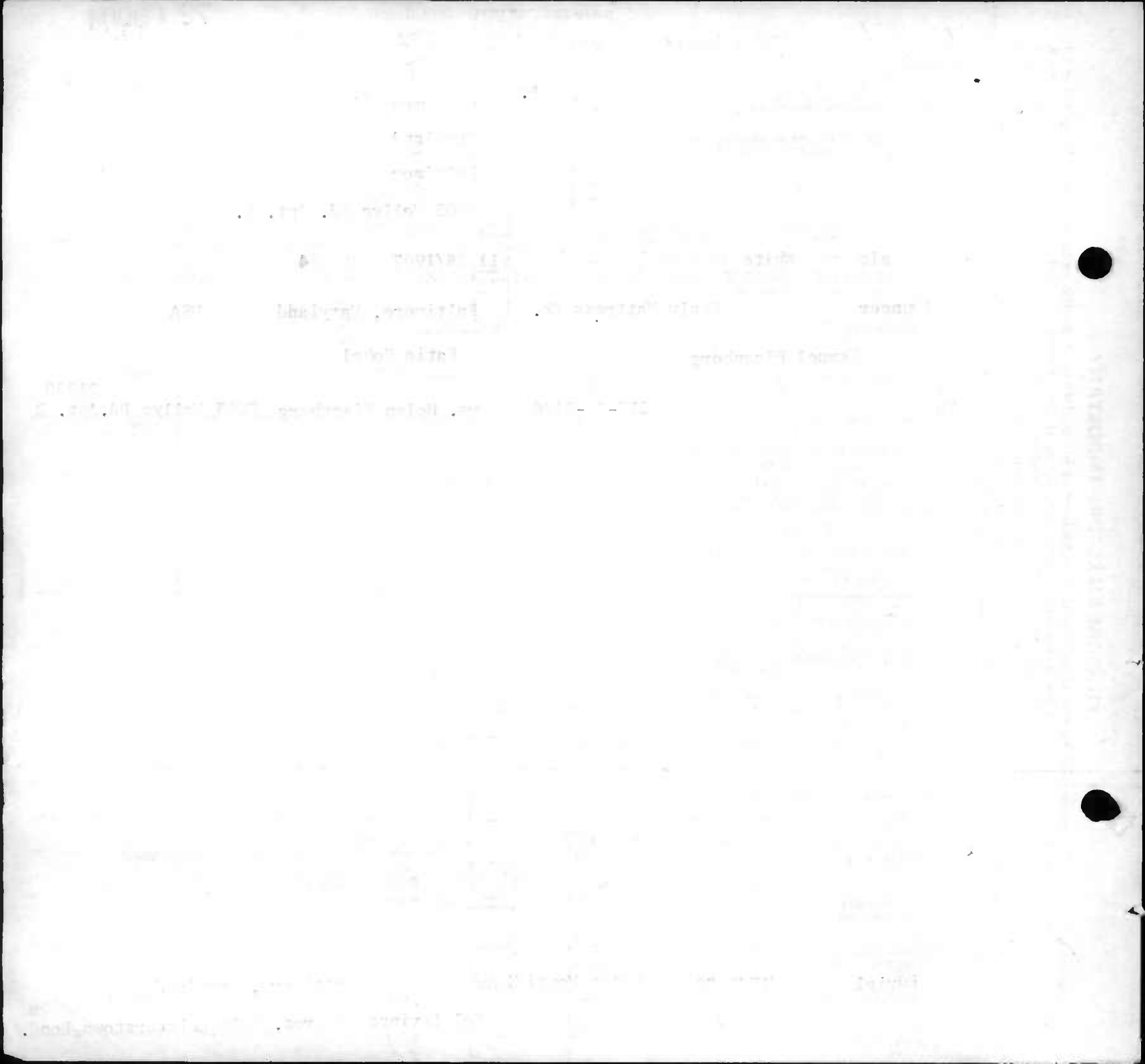
1. NAME OF DECEASED (Type or Print) <b>Stanley A Mirsky</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <b>9</b> Day <b>14</b> Year <b>72</b> Hour <b>8:45 P.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Sinai Hospital</b>		3. DATE PRONOUNCED DEAD Month <b>9</b> Day <b>14</b> Year <b>72</b> Hour <b>8:45 P.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
9. DATE OF BIRTH <b>Dec. 14, 1907</b>		10. AGE (In years last birthday) <b>64</b>	
11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Nathan Mirsky</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Vice President</b>	
15. MOTHER'S MAIDEN NAME <b>Sophie Slatkoff</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO. <b>297-07-2363</b>		18. INFORMANT ADDRESS <b>Mrs. Ruth Mirsky 5 Slade Ave. Apt. 621 21208</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>Sugar Cone Rd. at Greenspring Ave.</b>		22D. TIME (Month) (Day) (Year) (Hour) (Approx.) <b>9 14 72 4:15 P.m.</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Driver in auto-auto collision</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>W P Mulloy</b> M.D. EXAMINER'S NAME (Type) <b>William P. Mulloy, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>9-15-72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/17/1972</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Beth El Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Randallstown, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 20 1972</b>		25B. NAME OF REGISTRAR <b>Arthur Levinson</b>	
25C. FUNERAL DIRECTOR <b>Sol Levinson &amp; Bros. 6010 Reisterstown Rd.</b>		ADDRESS	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09004		REG. NO. 72 09004	
E-251				72 09004			
BIRTH NO.				72 09004			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
EISENBERG, LEONARD L.				9/14/72 8:50 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION				A. STATE B. COUNTY			
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				Maryland BALTO 5300			
Sinai Hosp. of Baltimore, Inc.				C. CITY OR TOWN D. INSIDE CITY LIMITS?			
4-2				Baltimore YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX 6. RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				E. STREET AND NUMBER			
Male White				8003 Mollye Rd. Apt. B.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)			
Manager				Baltimore, Maryland			
10B. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY?			
Sealy Mattress Co.				USA			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Samuel Eisenberg				Katie Sobel			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
No				217-18-5106			
17. INFORMANT				ADDRESS			
Mrs. Helen Eisenberg				21208 8003 Mollye Rd. Apt. B			
18. 599.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				Ham negative Septicemia			
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Urinary Tract infection as well as pneumonia			
(B) DUE TO, OR AS A CONSEQUENCE OF:				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Congestive heart failure; ASCVD			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Indicate medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (APPROX.)			
21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?			
White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>				22. I certify that (I) (this hospital) attended the deceased from 8/29 19 72 to 9/14 19 72 that (I) (we) last saw the deceased alive on 9/14 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE				23B. DATE SIGNED			
Veneranda C. Gerasimo, M.D.				9/14/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Veneranda C. Gerasimo M.D.				Sinai Hosp. of Baltimore, Inc.			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE			
Burial				9/17/1972			
24C. NAME OF CEMETERY OR CREMATORY				24D. LOCATION (City, town, or county) (State)			
Moses Montifiore				Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR			
SEP 20 1972				Sol Levinson & Bros. 6010 Reisterstown Road.			



# FUNERAL DIRECTOR: IMPORTANT

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B-260		72 09005		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09005	
BIRTH NO.		72 09005		CERTIFICATE OF DEATH		STATE OF MARYLAND-DEMH	
1. NAME OF DECEASED (Type or Print) <b>ROBERT BOOKER (LEE)</b>				2. DATE AND HOUR OF DEATH <b>9/19/72</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>39 PROVIDENT HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2037</b>			
				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>400 N. Hilton Street</b>			
5. SEX <b>M</b>	6. RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>DEC-10-1913</b>	9. AGE (in years last birthday) <b>58</b>	11. BIRTHPLACE (State or foreign country) <b>Richmond Virginia</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABOR</b>
13. FATHER'S NAME <b>JOE MASON</b>				14. MOTHER'S MAIDEN NAME <b>MARY BOOKER</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service				16. SOCIAL SECURITY NO. <b>224-07-4318</b>		17. INFORMANT <b>SISTER</b> ADDRESS <b>508-N-PACA-ST</b>	
18. <b>412.3 14188X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Ca. many years</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Acute Electrolyte Imbalance</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Chronic Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>ASHAD</b>			
19A. DATE OF OPERATION <b>0</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Indicate medical examined)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 (Month) 1 (Day) 1 (Year) 1 (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>7/2</b> 19 <b>72</b> to <b>9/19</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>9/19</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Deviderio L. Hebron Jr.</b> DEGREE						23B. DATE SIGNED <b>9/19/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>DEVIDERIO L. HEBRON JR.</b> DEGREE						23D. ADDRESS <b>2600 Liberty Heights Bldg. Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/22/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt Auburn Cemetry</b>		24D. LOCATION <b>Baltimore, Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 21 1972</b>		25B. NAME OF REGISTRAR <b>Deviderio L. Hebron Jr.</b>		25C. FUNERAL DIRECTOR <b>Deviderio L. Hebron Jr.</b>		ADDRESS <b>1206 North Ave</b>	



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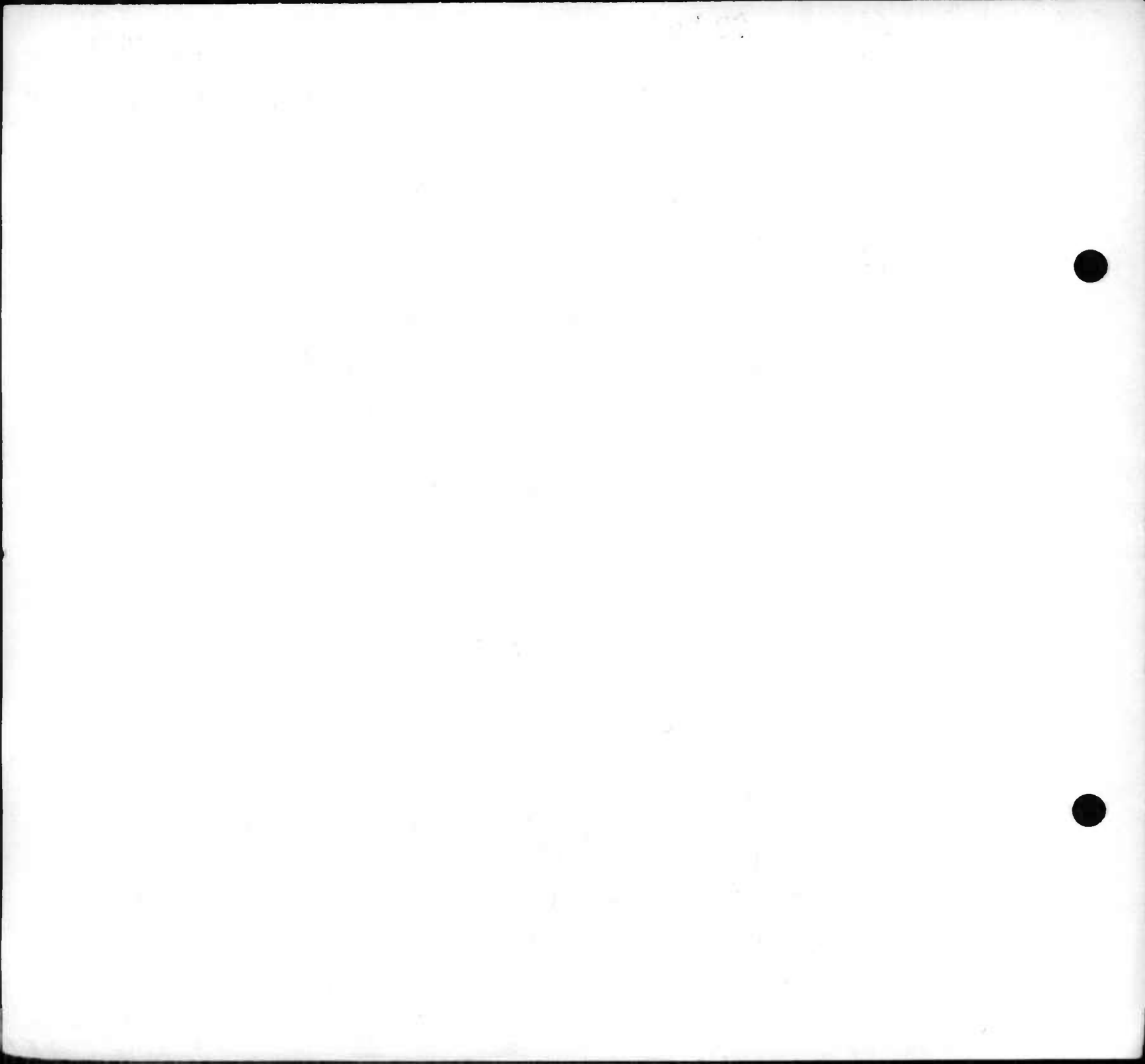
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 09006</b>	
BIRTH NO. <b>72-12512</b>				STATE OF <b>MARYLAND-DEME</b>	
1. NAME OF DECEASED (Type or Print) <b>baby girl wilkins</b>			2. DATE AND HOUR OF DEATH <b>August 31, 1972 12:45 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>46 Lutheran Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <b>MD</b> B. COUNTY <b>2037</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>103 N. Kossuth ST</b>		
5. SEX <b>female</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/31/72</b>	9. AGE (in years last birthday)	10. If Under 1 Yr. Months Days Hours 24 Hrs. Min. <b>20</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
13. FATHER'S NAME <b>unknown</b>			14. MOTHER'S MAIDEN NAME <b>BARBARA Wilkins</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>chart of mother</b> ADDRESS	
18. <b>777 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Immaturity (24 wks 1 pound)</b> DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>20 min.</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Unregistered</b>			19A. DATE OF OPERATION <b>0</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <b>No</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Aug 31 1972</b> to <b>Aug 31 1972</b> that (I) (we) last saw the deceased alive on <b>Aug 31 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Sung Y. Rhim, M.D.</b>			23B. DATE SIGNED <b>8/31/72</b>		23C. PHYSICIAN'S NAME (Type) <b>SANG Y. RHIM, M.D.</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>9-15-72 U of M. Anatomy Bldg.</b>			24B. DATE <b>9-15-72</b> 24C. NAME OF CEMETERY or CREMATORY <b>BALTIMORE</b> 24D. LOCATION (City, town, or county) (State) <b>BALTIMORE MD</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 21 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Johnston</b>		25C. FUNERAL DIRECTOR <b>R. J. CURRAN</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

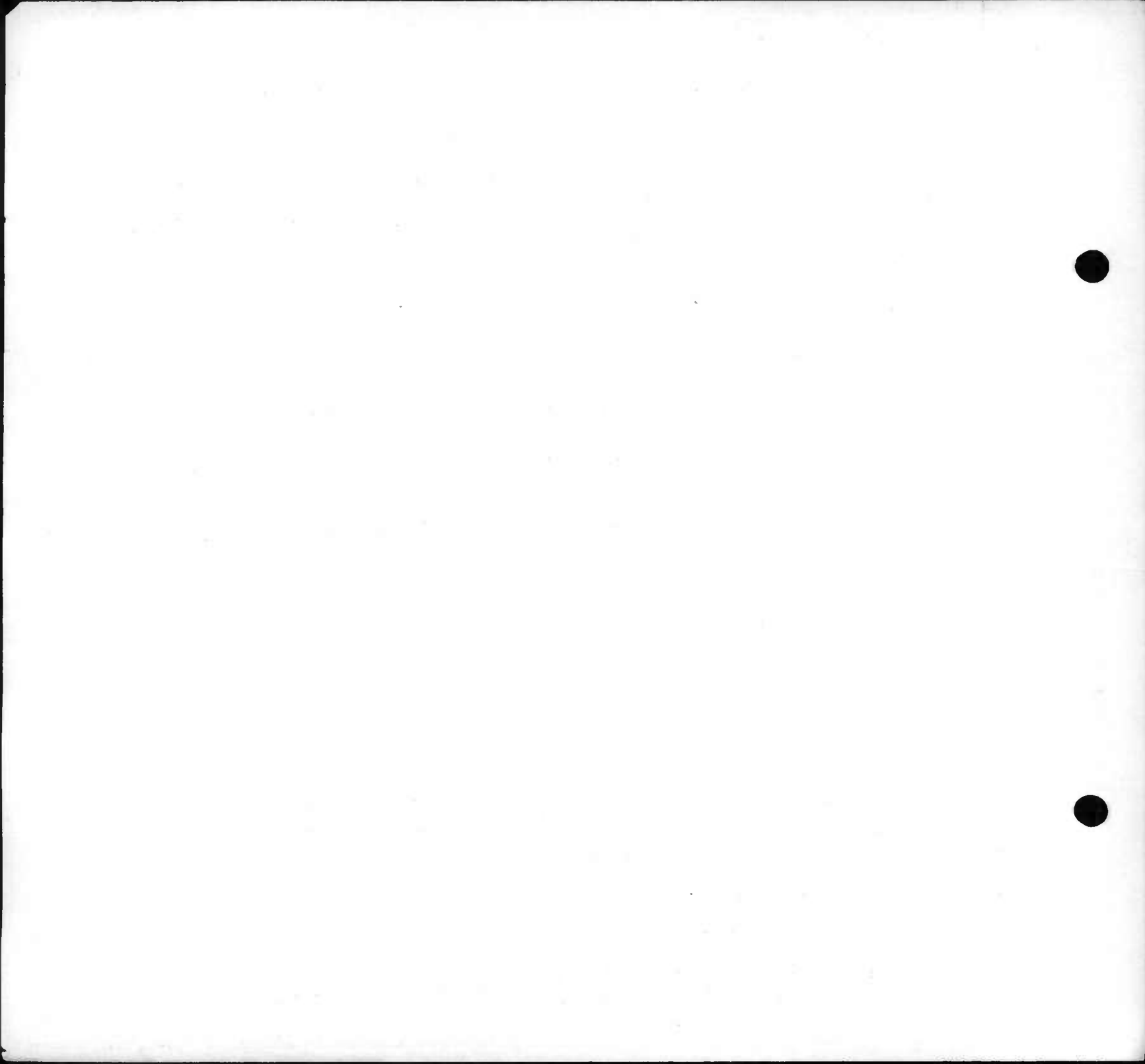
BALTIMORE CITY HEALTH DEPARTMENT				72 09007	
CERTIFICATE OF DEATH				REG. NO. 72 09007	
BIRTH NO. S-415 72 09007				STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print) <b>CHRISTOPHER SULLIVAN</b>		2. DATE AND HOUR OF DEATH <b>AUG 16 1972 5:30 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>UNIVERSITY HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) <b>MARYLAND</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY HOSPITAL</b>		CITY OR TOWN <b>SALISBURY</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>M</b>		6. RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <b>6/15/72</b>	
13. FATHER'S NAME <b>FRANK SULLIVAN</b>		14. MOTHER'S MAIDEN NAME <b>NOT KNOWN</b>		9. AGE (In years last birthday) <b>2</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
17. INFORMANT <b>HOSPITAL RECORDS</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		18. <b>770-81</b> CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>ORGANIC BRAIN DAMAGE</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>HYPER IMMUNEMIA</b> DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>7/2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>-153</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>7/2</b> 19 <b>72</b> to <b>8/16</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>8/16</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Edward H. Curran MD</b>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>EDWARD H. CURRAN</b>				23D. ADDRESS <b>UNIVERSITY HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>9-12-72</b>		24B. DATE <b>9-12-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>UOFM ANATOMY BOARD</b>	
24D. LOCATION <b>BALT. MD</b>		24E. NAME OF REGISTRAR <b>RAYMOND V. CURRAN</b>		24F. FURNERAL DIRECTOR <b>817 SCARLETT DRIVE TOWSON, MD 21204</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 21 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Johnston</b>		25C. FURNERAL DIRECTOR <b>RAYMOND V. CURRAN</b>	

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# FUNERAL DIRECTOR: IMPORTANT

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5-324		72 09008		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09008	
BIRTH NO.				STATE OF MARYLAND-DEATH			
1. NAME OF DECEASED (Type or Print) <b>BERNARD MARTIN STICKELL</b>				2. DATE AND HOUR OF DEATH <b>9/16/72 7:14 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SINAI HOSPITAL OF BALTIMORE, INC.</b>				C. CITY OR TOWN <b>BALT. COUNTY</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>M</b> 6. RACE <b>W</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>1/24/18</b>		9. AGE (In years last birthday) <b>54</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Elevator Inspector</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Government</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>	
13. FATHER'S NAME <b>BENJAMIN</b>				14. MOTHER'S MAIDEN NAME FIRST NAME - NOT KNOWN SECOND NAME <b>LYON</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>217-07-1675</b>		17. INFORMANT <b>WIFE</b> ADDRESS <b>VIRGINIA STICKELL - SAME</b>	
18. <b>410.9 I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>ACUTE MYOCARDIAL INFARCTION</b> ANTECEDENT CAUSES <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>HOURS</b> <b>YEARS</b>			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (4) (this hospital) attended the deceased from <b>9/16 1972</b> to <b>9/16 1972</b> that (4) (we) last saw the deceased alive on <b>9/16 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Ian Sunshine M.D.</b>				23B. DATE SIGNED <b>9/16/72</b>		23C. PHYSICIAN'S NAME (Type) <b>IAN SUNSHINE M.D.</b>	
24A. BURIAL-CREATION, REMOVAL (Specify) <b>SEP 21 1972</b>				24B. DATE <b>9-18-72</b>		24C. NAME of CEMETERY or CREMATORY <b>Gov. M. Anatomy Boro</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 21 1972</b>				25B. NAME OF REGISTRAR <b>Lidney W. Brown</b>		25C. FUNERAL DIRECTOR <b>RAMONA CURRAN</b>	
25D. LOCATION (City, town, or county) (State) <b>BALT. MD.</b>				25E. ADDRESS <b>817 SCARLETT DR TOWSON MD.</b>			

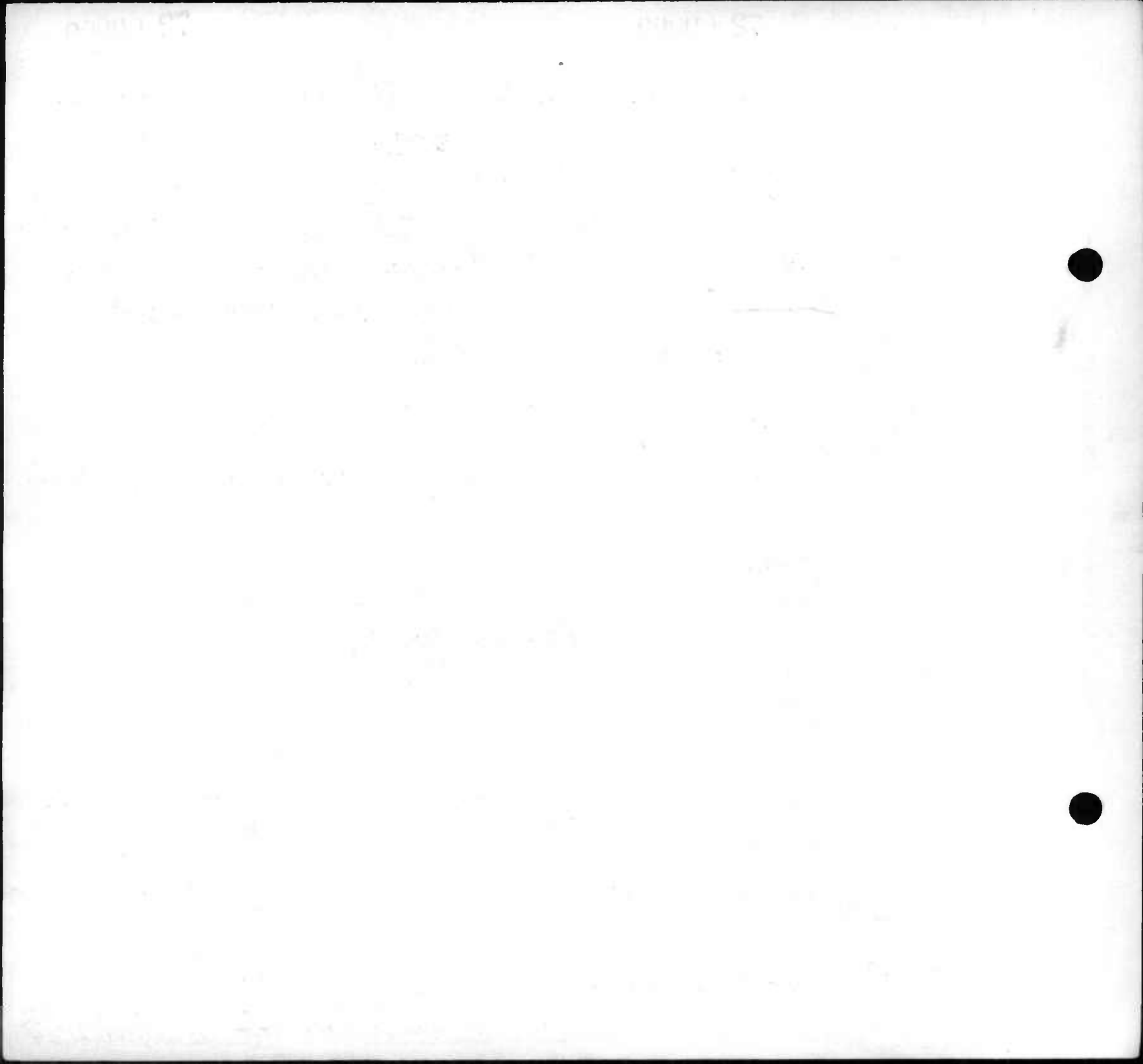




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<div style="display: flex; justify-content: space-between;"> <span>M-243 72 C9009</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> <span>72 C9009</span> </div>		
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO. 72-14423</span> <span>CERTIFICATE OF DEATH</span> <span>REG. NO. STATE OF MARYLAND-DHMH</span> </div>		
1. NAME OF DECEASED (Type or Print) <b>McLeod Baby GIRL</b>		2. DATE AND HOUR OF DEATH <b>9/10/72 8:30 p.m.</b>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SINAI Hospital of Baltimore</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>EMD.</b> B. COUNTY <b>1509</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>-3853 Forrest Pl AIE.</b>
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>9/10/72</b>		9. AGE (In years last birthday) <b>1 hr 15 min</b> If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) <b>SINAI Hospital</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>NOT KNOWN</b>		14. MOTHER'S MAIDEN NAME <b>NOT KNOWN</b>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>
17. INFORMANT <b>HOSP. RECORDS</b>		ADDRESS
18. <b>746.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>CONGENITAL HEART DS.</b> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr 15 min</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>PREMATURITY</b>		
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No) <b>yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>9/10/72</b> 19__ to <b>9/10</b> 19__ that (I) (we) last saw the deceased alive on <b>9/10</b> 19__ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.		
23A. SIGNATURE <b>McCleary MD</b>		23B. DATE SIGNED <b>9/10/72</b>
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS
24A. BURIAL CREMATION, REMOVAL (Specify) <b>REMOVED</b>		24B. DATE <b>7-18-72</b>
24C. NAME OF CEMETERY or CREMATORY <b>U of M ANATOMY Bldg</b>		24D. LOCATION (City, town, or county) (State) <b>BALT. MD</b>
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 21 1972</b>		25B. NAME OF REGISTRAR <b>Dr. J. H. H. H.</b>
25C. FUNERAL DIRECTOR <b>R. J. CURRAN</b>		ADDRESS <b>817 SCARLETT DR TOWSON, MD 21204</b>



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 09010

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>SHELLY MERRITT</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1228 E. Baltimore Street</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>August 26, 1972 7:30 P.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>5/11/04</b>		10. AGE (in years lost birthday) <b>68</b>	
11. BIRTHPLACE (State or foreign country) <b>NOT KNOWN</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>NOT KNOWN</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NOT KNOWN</b>		15. MOTHER'S MAIDEN NAME <b>NOT KNOWN</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) If yes, give war or dates of service <b>NOT KNOWN</b>		17. SOCIAL SECURITY NO. <b>577-28-1093</b>	
18. INFORMANT <b>BALTIMORE CITY MED. EXAMINER</b>		ADDRESS	
19. <b>7/12/72</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>9-18-72</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>No</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Peter Lipkovic, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>August 27, 1972</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL (CREMATION) REMOVAL (Specify)		24B. DATE <b>9-18-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>U.S. ANATOMY BOARD</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 21 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Wilson</b>	
25C. FUNERAL DIRECTOR <b>R.D. CURRAN</b>		ADDRESS <b>817 Scarb &amp; St. Towson Md. 21204</b>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09011 7	
BIRTH NO. 72-12504 72 09011				STATE OF MARYLAND - DHMH	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH	
Scott Daniel Adams ADAMS BABY BOY				8/29 8-03 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
SOUTH BALTIMORE GENERAL HOSPITAL 43 BALTIMORE.				MD. 2646	
5. SEX 6. RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
Male Caucasian				BALTO. YES <input type="checkbox"/> NO <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				E. STREET AND NUMBER	
NONE				6723 RAILWAY AVE.	
10B. KIND OF BUSINESS OR INDUSTRY				8. DATE OF BIRTH 9. AGE (In years last birthday) 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?	
				8/29/72 4 1/2 BALT. MD. U.S.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
CURTIS ADAMS				VIVIAN GARY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS	
No				No 101P RECORDS	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES				Int. ventricular hemorrhage	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Hyaline membrane disease	
				(C) Prematurity	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 8/29 1972 to 8/29 1972 that (H) (we) last saw the deceased alive on 8/29 1972 and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Seeni MD				8/29/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
SEENI				South Baltimore general Hospital Baltimore Md 21230.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
REMOVAL		9-12-72		UORM. ANATOMY BOARD	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
SEP 21 1972		Raymond Curran		Raymond Curran 812 Seaboard Ave. Towson MD	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09012 4	
B-520				72-13834 72 (9612) CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH	
B.G. BANKS				21 25 A.M. 29 Aug 72	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
SINAI HOSP. OF BALTIMORE				BALT. BALTIMORE 806	
5. SEX				6. RACE	
F				N	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH	
				8/28/72	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)	
				BALT. MD.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
Calvin Banks				CREOLA COUSINS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.	
17. INFORMANT				ADDRESS	
HOSP RECORDS					
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				RESPIRATORY & CARDIAC FAILURE	
(B) MASSIVE INTRACRANIAL HGE DUE TO, OR AS A CONSEQUENCE OF:					
(C) HYALINE MOH DISEASE					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug 28/72 1972 to Aug 29 1972 that (I) (we) last saw the deceased alive on Aug 29 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Silantagallany m.d.				29 Aug 72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
SILANTAGALLANY				SINAI HOSP. OF BALT.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
		9-18-72		BETH M. ANATOMY Bldg. BALT. MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
SEP 21 1972		Audrey Whitton		R.C. CURRAN TOWSON, MD 21204	



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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

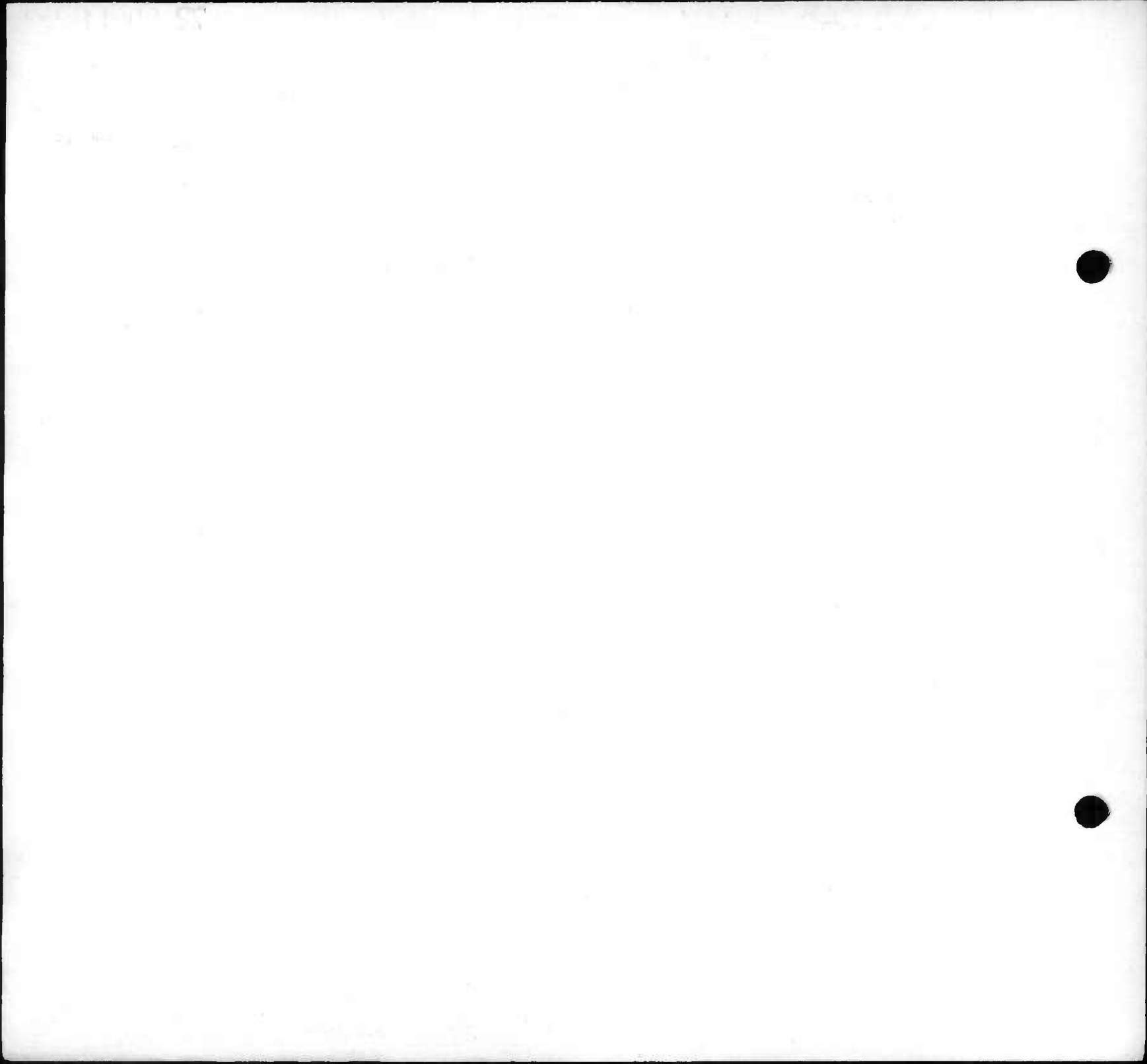
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 09013</b>	
B-260 72 09013				STATE OF MARYLAND-DEATH	
1. NAME OF DECEASED (Type or Print) <b>Roy Becker</b>		2. DATE AND HOUR OF DEATH <b>Sept 8, 1972 8:30 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>MARYLAND General Hospital</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>MALE</b> 6. RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-26-02</b> 9. AGE (In years last birthday) <b>70</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (State or foreign country) <b>Not Known</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Not Known</b>		14. MOTHER'S MAIDEN NAME <b>Not Known</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Not Known</b>		16. SOCIAL SECURITY NO. <b>Not Known</b>		17. INFORMANT <b>HOSPITAL RECORDS</b> ADDRESS	
18. <b>185X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Respiratory Failure</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Uremia</b> DUE TO, OR AS A CONSEQUENCE OF:		<b>1 month</b>	
(C) <b>Cc Prostate</b>				<b>2 YEARS</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>NONE</b>					
19A. DATE OF OPERATION <b>NONE</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NONE</b>		20A. AUTOPSY? (Yes or No) <b>NONE</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>NONE</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>NONE</b>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>NONE</b>		21E. INJURY OCCURRED <b>NONE</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>NONE</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>8/10 1972</b> to <b>9/8 1972</b> that (I) (we) last saw the deceased alive on <b>9/7 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Robert A. Cooper MD</b> DEGREE				23B. DATE SIGNED <b>9/8/72</b>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>9-15-72</b>		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY <b>UOEM ANATOMY BOARD</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MD</b>		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 21 1972</b>			
25B. NAME OF REGISTRAR <b>Andrew Johnston</b>		25C. FUNERAL DIRECTOR <b>RAYMOND CURRAN</b> ADDRESS <b>817 SCARLETT DR. TOWSON, MD. 21204</b>			

4016 E Lombard St.

5/31/72

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09014 4	
BIRTH NO. <u>B-255</u>				12-1323172 (9014)	
CERTIFICATE OF DEATH				REG. NO. <u>STATE OF MARYLAND-DEMD</u>	
1. NAME OF DECEASED (Type or Print) <u>Baby Boy Buchanan</u>			2. DATE AND HOUR OF DEATH <u>9-8-72</u>   <u>5<sup>16</sup> p.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Lutheran Hospital</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>2844</u>		
5. SEX <u>M</u>			6. RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>9/8/72</u>			9. AGE (In years last birthday) <u>12 hrs.</u>		If Under 1 Yr. Months: <u>12</u> Days: <u>12</u> Hours: <u>12</u> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>---</u>		
11. BIRTHPLACE (State or foreign country) <u>BALT. MD.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		
13. FATHER'S NAME <u>NOT KNOWN</u>			14. MOTHER'S MAIDEN NAME <u>Crystal Buchanan</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>HOSPITAL RECORDS</u> ADDRESS
18. <u>7789 I</u> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Cardio-respiratory arrest</u>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>prematurity</u>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Cristeta L. Gatdula MD</u> DEGREE				23B. DATE SIGNED <u>9-8-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>CRISTETA L. GATDULA MD</u> DEGREE				23D. ADDRESS	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>9-15-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>U. S. M. ANATOMY BLDG.</u>	
24D. LOCATION (City, town, or county) <u>BALT. MD.</u>		24E. LOCATION (State) <u>BALT. MD.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 21 1972</u>		25B. NAME OF REGISTRAR <u>Arlene Johnston</u>		25C. FUNERAL DIRECTOR <u>R. J. CURRAN</u> ADDRESS <u>807 SEA CLIFF DR TOWSON, MD.</u>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) J. ROLAND DOUGHERTY		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 2123 Maryland Avenue		3. DATE PRONOUNCED DEAD Month Day Year September 5, 1972 8:00 P. M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1206		6. SEX Male 7. RACE White 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Not Known 10. AGE (In years lost birthday) 67 11. BIRTHPLACE (State or foreign country) Not Known		12. CITIZEN OF WHAT COUNTRY? Not Known	
13. FATHER'S NAME Not Known		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not Known	
15. MOTHER'S MAIDEN NAME Not Known		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Not Known	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Balt City Med. Examiner's Office	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Gunshot wound of chest CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION 21. AUTOPSY? (Yes or No) yes		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
22C. WHERE DID INJURY OCCUR? 2123 Maryland Avenue		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 8/31/72 9/5/72	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Self-inflicted	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE William P. Mulloy, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 9/6/72			
24A. BURIAL (Cremation, Removal) (Specify)		24B. DATE 8-18-72	
24C. NAME OF CEMETERY or CREMATORY UOFM Quarmy Bldg. BALT. MD		24D. LOCATION (City, town or county) (State) BALT. MD	
25A. DATE REC'D BY HEALTH DEPT. SEP 21 1972		25B. NAME OF REGISTRAR Andrew P. K... 25C. FUNERAL DIRECTOR R. CURRAN 87 South... TOWSON MD 121204	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09016	
CERTIFICATE OF DEATH				REG. NO. 72 09016	
1. NAME OF DECEASED (Type or Print) <b>FLETCHER WILLIAM J.</b>		2. DATE AND HOUR OF DEATH <b>9-5-1972</b>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>43 SOUTH BALTIMORE HOSP.</b>	
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2004</b>		5. CITY OR TOWN <b>BALTIMORE</b>		6. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
7. STREET AND NUMBER <b>1213 LIGHT STREET</b>		8. DATE OF BIRTH <b>1-15-1900</b>			
9. AGE (In years last birthday) <b>72</b>		10. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		11. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
12. SEX <b>M</b>		13. RACE <b>W</b>		14. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNKNOWN</b>		16. KIND OF BUSINESS OR INDUSTRY <b>UNKNOWN</b>		17. FATHER'S NAME <b>JOHN (dec.)</b>	
18. MOTHER'S MAIDEN NAME <b>MARY (?) (dec.)</b>		19. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b>		20. SOCIAL SECURITY NO. <b>UNKNOWN</b>	
21. INFORMANT <b>HOSPITAL RECORDS</b>		22. ADDRESS			
23. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>HEPATIC COMA</b>		24. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>LIVER CIRRHOSIS - etiology</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>unknown</b> (C) <b>unknown</b>			
25. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>POSSIBLE MALIGNANCY OF THE LIVER - PRIMARY OR METASTATIC</b>		26. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
27. MEDICAL CERTIFICATION 19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		23. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			
24. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		25. HOW DID INJURY OCCUR?			
26. I certify that (X) (this hospital) attended the deceased from <b>7-28-</b> <b>1972</b> to <b>9-5-</b> <b>1972</b> that (I) (we) last saw the deceased alive on <b>9-5-</b> <b>1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
27. SIGNATURE <b>Julia Toshoff, M.D.</b>		28. DATE SIGNED <b>9-5-1972</b>		29. PHYSICIAN'S NAME (Type) <b>JULI TOSHEFF, M.D.</b>	
30. ADDRESS <b>2085 Woodbourne Ave, Baltimore, Md. 21239</b>		31. DATE OF OPERATION <b>9-12-72</b>			
32. NAME OF CEMETERY OR CREMATORY <b>U of M. Anatomy Board</b>		33. LOCATION <b>BALTIMORE, MD</b>		34. CITY, TOWN, OR COUNTY (State)	
35. DATE REC'D BY HEALTH DEPT. <b>SEP 21 1972</b>		36. NAME OF REGISTRAR <b>Raymond C. Carr</b>		37. FUNERAL DIRECTOR <b>817 S. E. ...</b>	

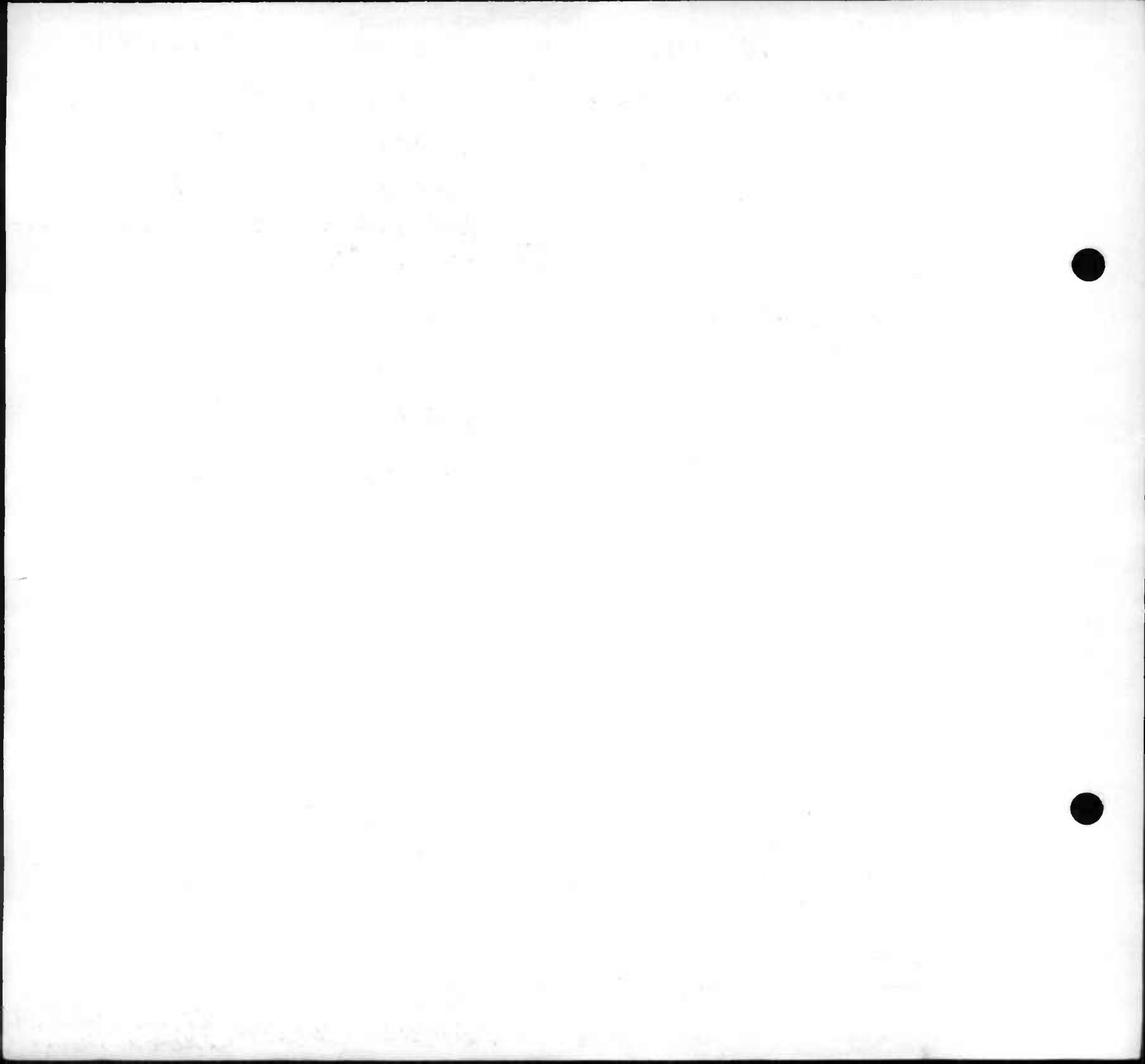
3/13/72 - Adm

2306 Frederick Ave. 21223

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 72 09017	
BIRTH NO. 12-14238 72 09017				STATE OF MARYLAND-DHMH		4	
1. NAME OF DECEASED (Type or Print) <b>HAIRSTON, Baby Girl</b>				2. DATE AND HOUR OF DEATH <b>8:45 pm 9/15/72</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI Hospital</b>				A. STATE <b>MARYLAND</b> B. COUNTY <b>BALT CITY</b>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <b>BALT</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <b>NOT KNOWN 5024 DENVER AVE</b>							
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/15/72</b>	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NEVER EMPLOYED</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>USA, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>NOT KNOWN</b>				14. MOTHER'S MAIDEN NAME <b>HAIRSTON</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>HOSPITAL RECORDS</b>	
18. <b>777X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <b>PREMATURITY</b> DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>-</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>9/15</b> 19 <b>72</b> to <b>9/15</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>9/15</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour, and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>D. McCleary MD</b>				23B. DATE SIGNED <b>9/15/72</b>		23C. PHYSICIAN'S NAME (Type) <b>D. McCleary MD</b>	
23D. ADDRESS <b>DEGREE</b>				23E. ADDRESS			
24A. BURIAL CREMATION, RELOCATION (Specify)		24B. DATE <b>9-18-72</b>		24C. NAME of CEMETERY or CREMATORY <b>WORM HOLE BOARD</b>		24D. LOCATION (City, town, or county) (State) <b>BALT MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 21 1972</b>		25B. NAME OF REGISTRAR <b>Libby Hinton</b>		25C. FUNERAL DIRECTOR <b>RAYMOND J. CUREAN</b>		25D. ADDRESS <b>817 S. ...</b>	

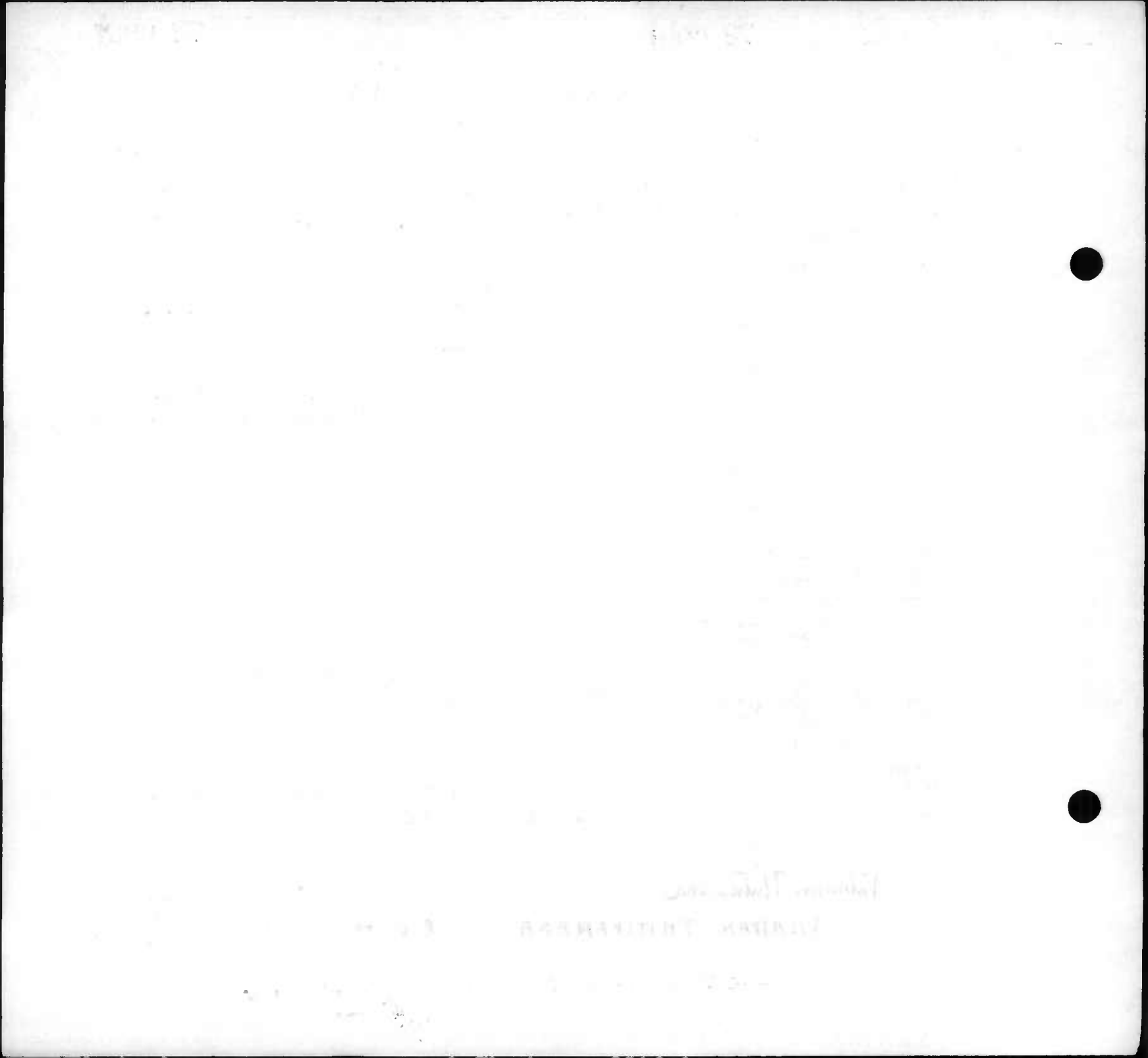


61-82-75 air

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

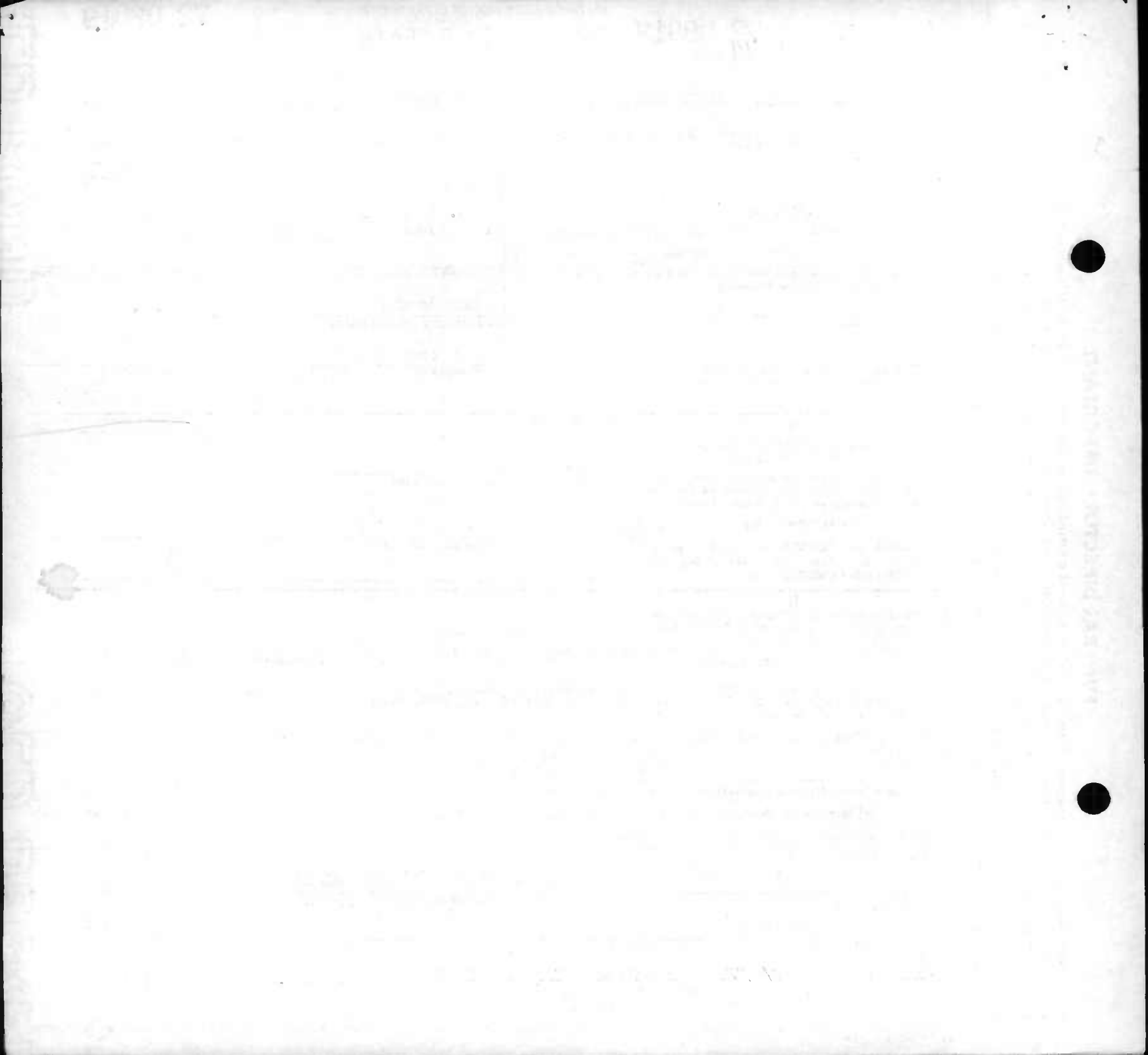
BIRTH NO. <u>S-320 72 C9018</u>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>72 096185</u>	
1. NAME OF DECEASED (Type or Print) <u>Shoots, Boy Carrie</u>				2. DATE AND HOUR OF DEATH <u>9-8-72</u> <u>1:05 A</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>802</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Baltimore City Hospital</u> <u>4940 Eastern Avenue Baltimore, Maryland</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Male</u> 6. RACE <u>Negro</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>9/7/72</u>		9. AGE (In years last birthday) <u>1</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Fred</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>BCH: RECORDS Baltimore, Maryland 21224</u> ADDRESS <u>4940 Eastern Avenue</u>	
18. <u>776-9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Respiratory and Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Immaturity</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>9-7</u> 19 <u>72</u> to <u>9-8</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>9-8</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Vilairan Thitivarana</u>				23B. DATE SIGNED <u>9-8-72</u>		23C. PHYSICIAN'S NAME (Type) <u>VILAIRAN THITIVARANA</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremated</u>				24B. DATE <u>9-9-1972</u>		24C. NAME OF CEMETERY or CREMATORY <u>Baltimore City Hospitals</u>	
24D. LOCATION (City, town, or county) <u>Baltimore, Md.</u>				24E. ADDRESS <u>21224</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 21 1972</u>				25B. NAME OF REGISTRAR <u>Lidney</u>			
25C. FUNERAL DIRECTOR <u>HOSPITAL DISPOSAL</u>				25D. ADDRESS			



61-79-08

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 672-09019	
T-460-12-14247 09019				72-09019	
BIRTH NO.				STATE OF MARYLAND-DEMH	
1. NAME OF DECEASED (Type or Print) <i>Tyler Boy Deborah</i>			2. DATE AND HOUR OF DEATH <i>9-2-72 = 7:30 A.M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <i>Eastern Avenue</i> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <i>Baltimore City Hospitals</i> <i>Baltimore Maryland 21224</i>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Anne Arundel</i> C. CITY OR TOWN <i>Patuxent</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <i>Rt. 2 Box 145 Patuxent 20220</i>		
5. SEX <i>Male</i>	6. RACE <i>Caucasian</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/1/72</i>	9. AGE (In years last birthday) <i>1</i>	10. IF Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME			
14. MOTHER'S MAIDEN NAME <i>Deborah Tyler</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT <i>4940 Eastern Avenue</i> BCH: RECORDS Baltimore, Maryland 21224			
18. <i>776.2 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cardio-respiratory arrest</i> <i>1) Respiratory distress syndrome</i> <i>2) Prematurity (29 weeks)</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
19. DATE OF OPERATION			19A. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) <i>Yes</i>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>9-1</i> 19 <i>72</i> to <i>9-2</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>9-2</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Vilaviron</i>			23B. DATE SIGNED <i>9-2-72</i>		
23C. PHYSICIAN'S NAME (Type) <i>VILAVIRON</i>			23D. ADDRESS <i>4940 Eastern Avenue</i> <i>B. C. H.</i> Baltimore, Maryland 21224		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Cremated</i>		24B. DATE <i>9/6/72</i>		24C. NAME OF CEMETERY or CREMATORY <i>Baltimore City Hospitals</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		24E. ADDRESS <i>21224</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 21 1972</i>		25B. NAME OF REGISTRAR <i>Adrienne Johnson</i>		25C. FUNERAL DIRECTOR <i>HOSPITAL DISPOSAL</i>	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

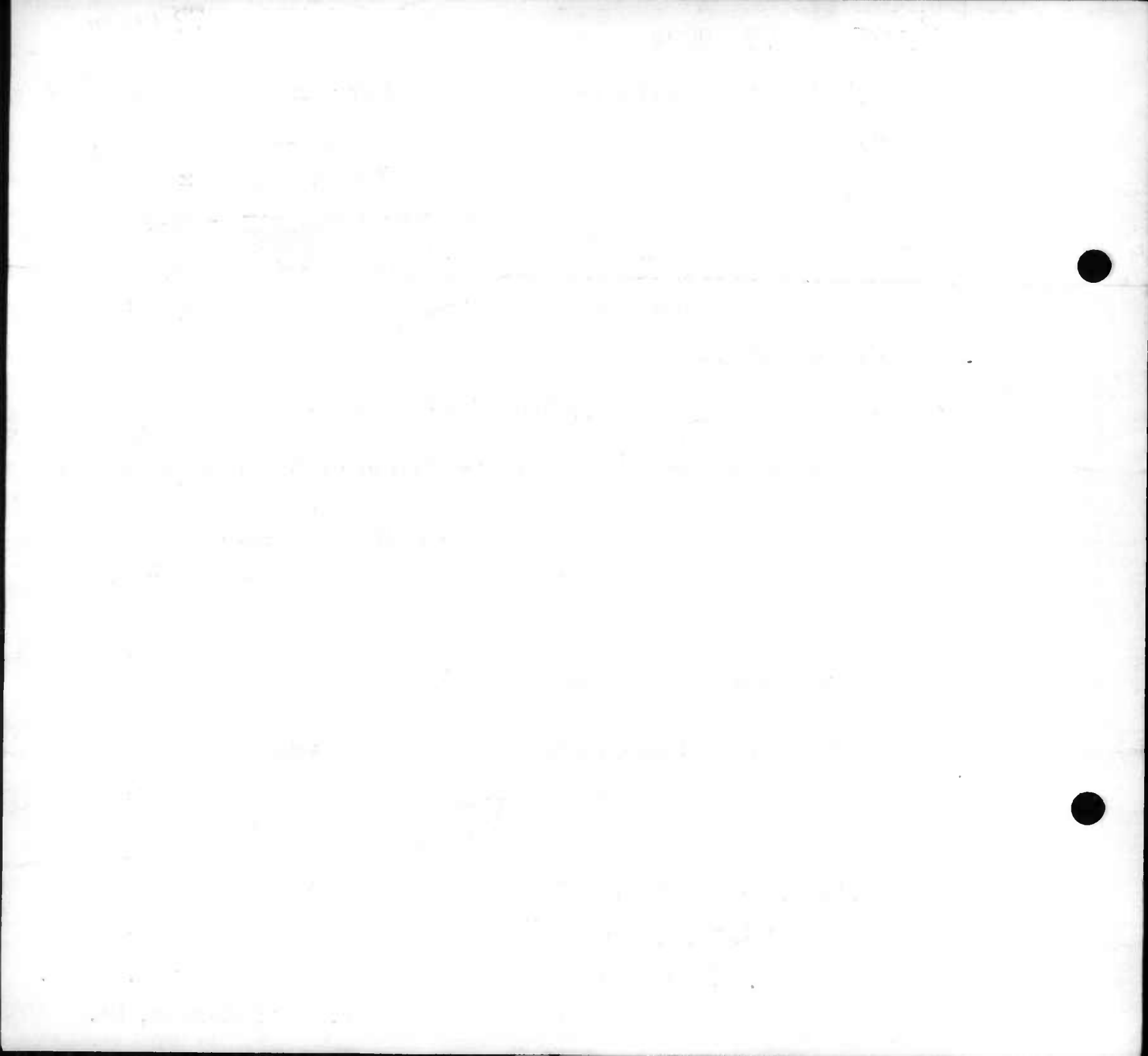




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		72 09020		REG. NO.		72 09020	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		STATE OF MARYLAND-DHMH					
EVA MAY ROUTZAHN		9-18-72		11 43 A.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE MD.		B. COUNTY Frederick			
UNIV. MD. HOSPITAL				C. CITY OR TOWN MIDDLETOWN		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER W. MAIN ST. — 21769					
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-13-93	9. AGE (in years last birthday) 79	10. If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY USA			
13. FATHER'S NAME T. FRANK HIGHTMAN				14. MOTHER'S MAIDEN NAME MINNIE STINE					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-28-0931		17. INFORMANT HOSP FACE SHEET		ADDRESS			
18. CAUSE OF DEATH						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: VENTRICULAR ARRHYTHMIA CARDIAC FAILURE & RESPIRATORY INSUFFICIENCY (B) DUE TO, OR AS A CONSEQUENCE OF: CANCER COMPRESSING TRACHEA (C)		2 1/2 days 76 hrs 1/2 wks 8 wks			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION 9-5-72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED TRACHEAL COMPRESSION		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 9-2-72 19 to 9-18-72 19 that (I) (we) last saw the deceased alive on 9-18-72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE J. KASTYTIS JAMARIS M.D.				23B. DATE SIGNED 9-18-72					
23C. PHYSICIAN'S NAME (Type) J. KASTYTIS JAMARIS M.D.				23D. ADDRESS 5142 WESTLAND BLVD.					
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE Sept. 21, 72		24C. NAME of CEMETERY or CREMATORY Lutheran Cemetery		24D. LOCATION (City, town, or county) (State) Middletown Fred. Md.			
25A. DATE REC'D BY HEALTH DEPT. SEP 21 1972		25B. NAME OF REGISTRAR Audrey M. [Signature]		25C. FUNERAL DIRECTOR Gladhill Co.		ADDRESS Middletown, Md.			



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased prior to death; and (6) No physician who pronounced death was in regular attendance on the deceased prior to death; and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-420						72 09021						BALTIMORE CITY HEALTH DEPARTMENT						REG. NO.						72 09021											
BIRTH NO.																																			
1. NAME OF DECEASED (Type or Print)																		2. DATE AND HOUR OF DEATH																	
SLACK, ETHEL LUCILLA																		SEPTEMBER 18, 1972   9:50 P. M.																	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD																		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)																	
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229																		A. STATE MARYLAND C. CITY OR TOWN SYKESVILLE E. STREET AND NUMBER ROUTE 99 12525																	
5. SEX FEMALE																		6. RACE CAUCASIAN																	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>																		8. DATE OF BIRTH 07/22/94																	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE																		10B. KIND OF BUSINESS OR INDUSTRY at Home																	
11. BIRTHPLACE (State or foreign country) MARYLAND																		12. CITIZEN OF WHAT COUNTRY? U.S.A.																	
13. FATHER'S NAME GEORGE ARRINGTON																		14. MOTHER'S MAIDEN NAME SARAH ROBINSON																	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no																		16. SOCIAL SECURITY NO. 213 74 0805																	
17. INFORMANT WILKENS AVES BALTO MD 21229 ST AGNES HOSPITAL'S RECORDS CATON &																		ADDRESS																	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.																		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Gargenous of Small Intestine Days</i> (B) <i>Volvulus of Small Bowel Days</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____																	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>cys.</i>																	
19A. DATE OF OPERATION 19/12/72																		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Gargenous bowels</i>																	
20A. AUTOPSY? (Yes or No) no																		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																	
21A. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)																		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)																	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)																																			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)																		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>																	
21F. HOW DID INJURY OCCUR?																																			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from SEPTEMBER 16 19 72 to SEPTEMBER 18 19 72, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on SEPTEMBER 18 19 72 and that in my <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. ( <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.																																			
23A. SIGNATURE <i>C.R. Chaney M.D.</i>																		23B. DATE SIGNED 9/18/72																	
23C. PHYSICIAN'S NAME (Type) C. R. CHANEY M.D.																		23D. ADDRESS BALTIMORE, MARYLAND 21229 ST. AGNES HOSPITAL-CATON & WILKENS AVES																	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial																		24B. DATE 9/22/72																	
24C. NAME OF CEMETERY or CREMATORY Mt. View Cem.																		24D. LOCATION (City, town, or county) (State) Marriottsville, Howard Co. Md.																	
25A. DATE REC'D BY HEALTH DEPT. SEP 21 1972																		25B. NAME OF REGISTRAR <i>Larry H. [illegible]</i>																	
25C. FUNERAL DIRECTOR Slack Funeral Home Ellicott City, Md. 21043																		ADDRESS																	

15000 35

100

BLACK, EVELYN LILLIAN

SEPTEMBER 18, 1932

MARYLAND

1932

ST. AGNES HOSPITAL  
CATHY & WILLIAMS AVENUE

1932

ROUTE 20 1932

WILMINGTON, MARYLAND 21801

XX

WILMINGTON

1932

MARYLAND

WILMINGTON

1932

WILMINGTON

WILKINS AVE. BALTIMORE 21201

ST. AGNES HOSPITAL'S RECORD CATHY

SEPTEMBER 18

SEPTEMBER 18

XXXX

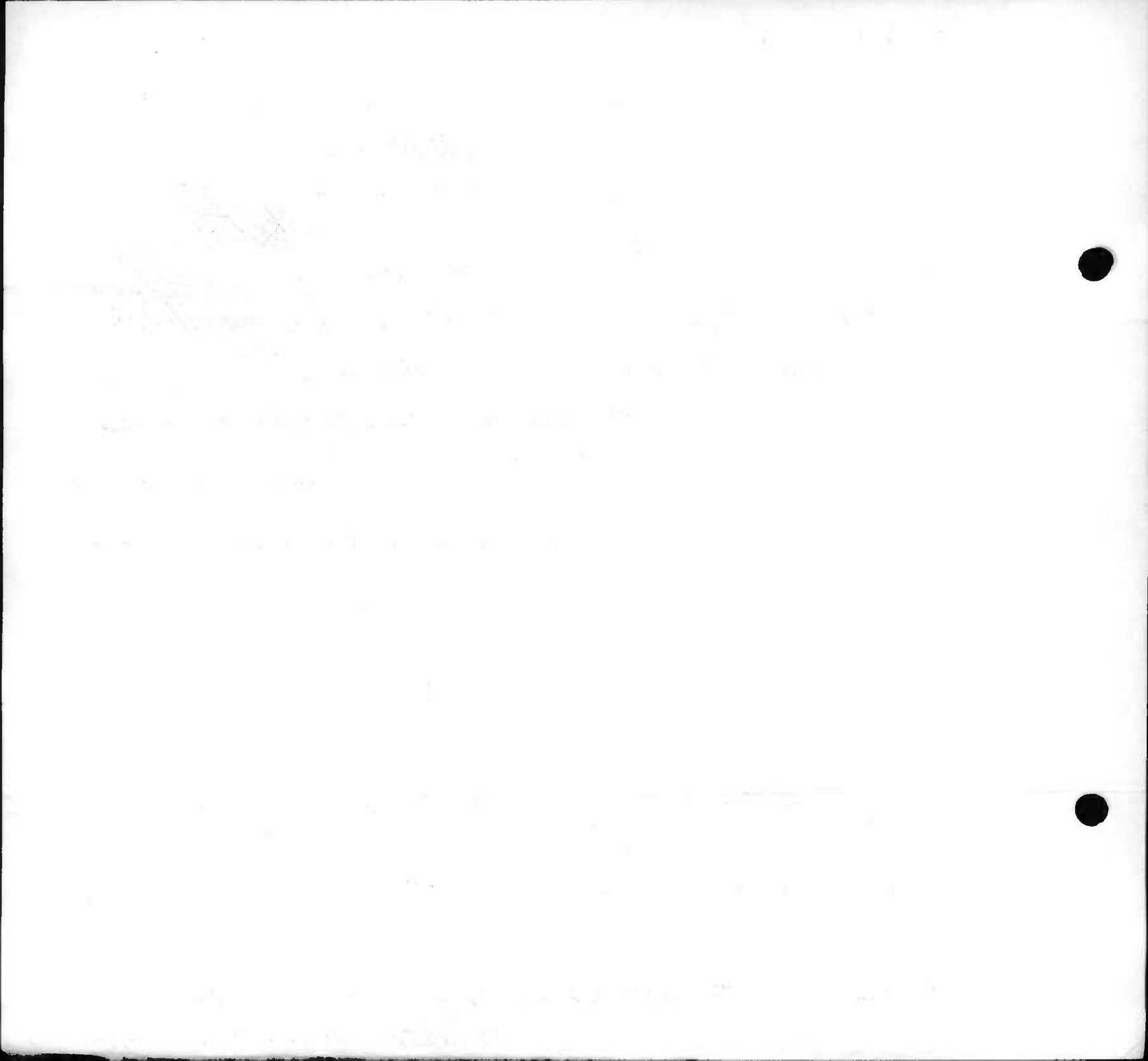
BALTIMORE, MARYLAND 21201  
ST. AGNES HOSPITAL-CATHY & WILLIAMS AVE.

C. R. CHANEY M.D.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-560		72 09022		BALTIMORE CITY HEALTH DEPARTMENT		72 09022	
BIRTH NO.		CERTIFICATE OF DEATH				REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		STATE OF MARYLAND-DEMHE			
Arthur S. Roemer		9-17-72 11 30 P M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY			
00 2426 Pickwick Rd		Maryland		2833			
C. CITY OR TOWN		D. INSIDE CITY LIMITS?					
Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
E. STREET AND NUMBER		2426 Pickwick Rd					
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
M W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		6-18-1901		9. AGE (In years last birthday) 71	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Industrial Goods Rep.				Cleveland, Ohio		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
Arthur M. Roemer		Ivella Solis					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
		152-07-1420		Mary Elizabeth Roemer-Same			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		WIDE SPREAD METASTATIC CARCINOMA				1 MONTH	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) CARCINOMA OF PALMARS				3 MRS	
		(C) _____					
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPRX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from 16 MARCH 19 71 to 17 SEPT 1972 that (I) ( <del>was</del> ) last saw the deceased alive on 21 AUG 19 72 and that in (my) ( <del>my</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>was</del> ) ( <del>did not</del> ) view the body after death.							
23A. SIGNATURE		23B. DATE SIGNED		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			
15- Mills		18 Sept 72					
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		9-20-72		Lorraine Cemetery		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
SEP 21 1972		Frederick H. H. H.		Premast Funeral Chapel		4604 Liberty Heights	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-264		72 09023		BALTIMORE CITY HEALTH DEPARTMENT		72 09023	
CERTIFICATE OF DEATH				REG. NO.		STATE OF MARYLAND-DEHE	
1. NAME OF DECEASED (Type or Print) <u>Di Carlo, Nicholas T.</u>				2. DATE AND HOUR OF DEATH <u>9/17/72</u> <u>6</u> <u>4</u> <u>PM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>University of Md. Hospital</u> <u>38</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Spring Grove St. Hospital</u> 5300 C. CITY OR TOWN <u>Balto. Md.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER			
5. SEX <u>M</u>	6. RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>9-19-06</u>	9. AGE (In years last birthday) <u>65</u>	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	12. CITIZEN OF WHAT COUNTRY?
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>A &amp; P</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland, Baltimore</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>Frank DiCarlo</u>				14. MOTHER'S MAIDEN NAME <u>Gesualda Gienopla</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>216-7-6840</u>		17. INFORMANT <u>927 N. Kresson St.</u> ADDRESS <u>21205</u> <u>Edward J. DiCarlo, brother</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>Fractured Hip</u>				19. CAUSE OF DEATH IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pneumonia</u>  DUE TO, OR AS A CONSEQUENCE OF: <u>Fractured Hip</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				<u>Fractured Hip</u>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Spring Grove State Hosp</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>Spring Grove State Hosp</u> 5300			
21D. TIME OF INJURY (APPROX.) <u>8 21 72</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>Fall</u>			
22. I certify that (I) (this hospital) attended the deceased from <u>9/17</u> to <u>9/17</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>9/17</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Donald E. Gley</u>				23B. DATE SIGNED <u>9/17/72</u>			
23C. PHYSICIAN'S NAME (Type) <u>Donald E. Gley</u>				23D. ADDRESS <u>Schimunek Funeral Home, Inc.</u> <u>3331 Brehms Lane</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/19/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Gardens of Faith</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 21 1972</u>		25B. NAME OF REGISTRAR <u>Disney</u>		25C. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u>		ADDRESS <u>3331 Brehms Lane</u>	

7/13/38 - Adm.



B-450

72 09024

STATE OF MARYLAND-DEPT.  
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 09024

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Valentine John/Bohlen Jr.</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>9 17 72</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Balto. City Hospital</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>9 17 72 3:00 p.</b> M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>BALTO</b>				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
6. SEX <b>male</b>	7. RACE <b>White</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>July 8, 1937</b>		10. AGE (In years last birthday) <b>35</b>		E. STREET AND NUMBER <b>Box 316, Rt. 16, Baltimore, Md. 21220</b>	
11. BIRTHPLACE (State or foreign country) <b>Essex, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John V. Bohlen</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Asst. Foreman</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>General Motors</b>		15. MOTHER'S MAIDEN NAME <b>Margaret E. Arvey</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes Army 1963</b>		17. SOCIAL SECURITY NO. <b>216-34-2410</b>		18. INFORMANT ADDRESS <b>Mrs. Margaret Rychwalski, mother, above</b>	
19. <b>E 965X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CAUSE LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH <b>Bronchopneumonia and peritonitis</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Gunshot wounds of chest</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>INN</b>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>Cheverlet Inn - Broening Hwy. 2626</b>	
22D. TIME OF INJURY (APPROX.) Month Day Year Hour <b>8 18 72 10:24 p.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Subject shot during hold-up</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b> DATE SIGNED <b>9/18/72</b> EXAMINER'S NAME (Type)					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/21/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Sacred Heart Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 21 1972</b>		25B. NAME OF REGISTRAR <b>John P. [Signature]</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Schimunek Funeral Home, Inc. 3931 Brehms Lane</b>	

N 875. A

6019 HOLABIRD AVE 1900 SS

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 09025</b>	
B-550 72 09025				STATE OF MARYLAND-DEATH	
1. NAME OF DECEASED (Type or Print) <b>MAUDE Bowman</b>			2. DATE AND HOUR OF DEATH <b>9-18-72 8:30 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>HAMILTON NURSING CENTER 6040 HARBOR RD. HAMILTON</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2608</b>		
			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>33 S. Highland Ave.</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIAGE STATUS MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-12-84</b>		9. AGE (In years last birthday) <b>88</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Chestertown, Md.</b>	
13. FATHER'S NAME <b>Brown</b>			14. MOTHER'S MAIDEN NAME <b>unknown</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-54-0157J</b>		17. INFORMANT <b>E. Williams</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardiac arrest</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>arterio-sclerotic heart dis.</b>		
			(B) DUE TO, OR AS A CONSEQUENCE OF: <b>1 year</b>		
			(C) DUE TO, OR AS A CONSEQUENCE OF: <b>2 years</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Diabetes mellitus</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4-19-72</b> to <b>9-18-72</b> , that (I) (we) last saw the deceased alive on <b>9-18-72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>W. K. Wong</b>				23B. DATE SIGNED <b>9/19/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>W. K. Wong</b>				23D. ADDRESS <b>6801 Belair Rd 21206</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/22/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 21 1972</b>		25B. NAME OF REGISTRAR <b>Frederick</b>		25C. FUNERAL DIRECTOR <b>Schmunk Funeral Home, Inc.</b>	
				ADDRESS <b>3331 Brehms Lane</b>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) John Bearer		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 9 Day 17 Year 72 Hour 2:10A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) University Hospital		3. DATE PRONOUNCED DEAD Month 9 Day 17 Year 72 Hour 2:10 A.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH May 23/1954		10. AGE (in years last birthday) 18	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales		14B. KIND OF BUSINESS OR INDUSTRY Sea Food	
15. MOTHER'S MAIDEN NAME Williams		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 206-44-1560		18. INFORMANT Thelma Jimlin 118 N GREEN ST	
19. CAUSE OF DEATH E965 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street 108		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? in front of 316 S. Poppleton St. 2102	
22D. TIME OF INJURY (APPROX.) 9 17 72 12:43A.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? shot during altercation		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) William P. Mulloy, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) 9/21/72		24B. DATE 9/21/72	
24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Fredrick Ave	
25A. DATE REC'D BY HEALTH DEPT. SEP 21 1972		25B. NAME OF REGISTRAR 0	
25C. FUNERAL DIRECTOR 5 Thomas J. KENNY		ADDRESS 1600 Hollins St.	

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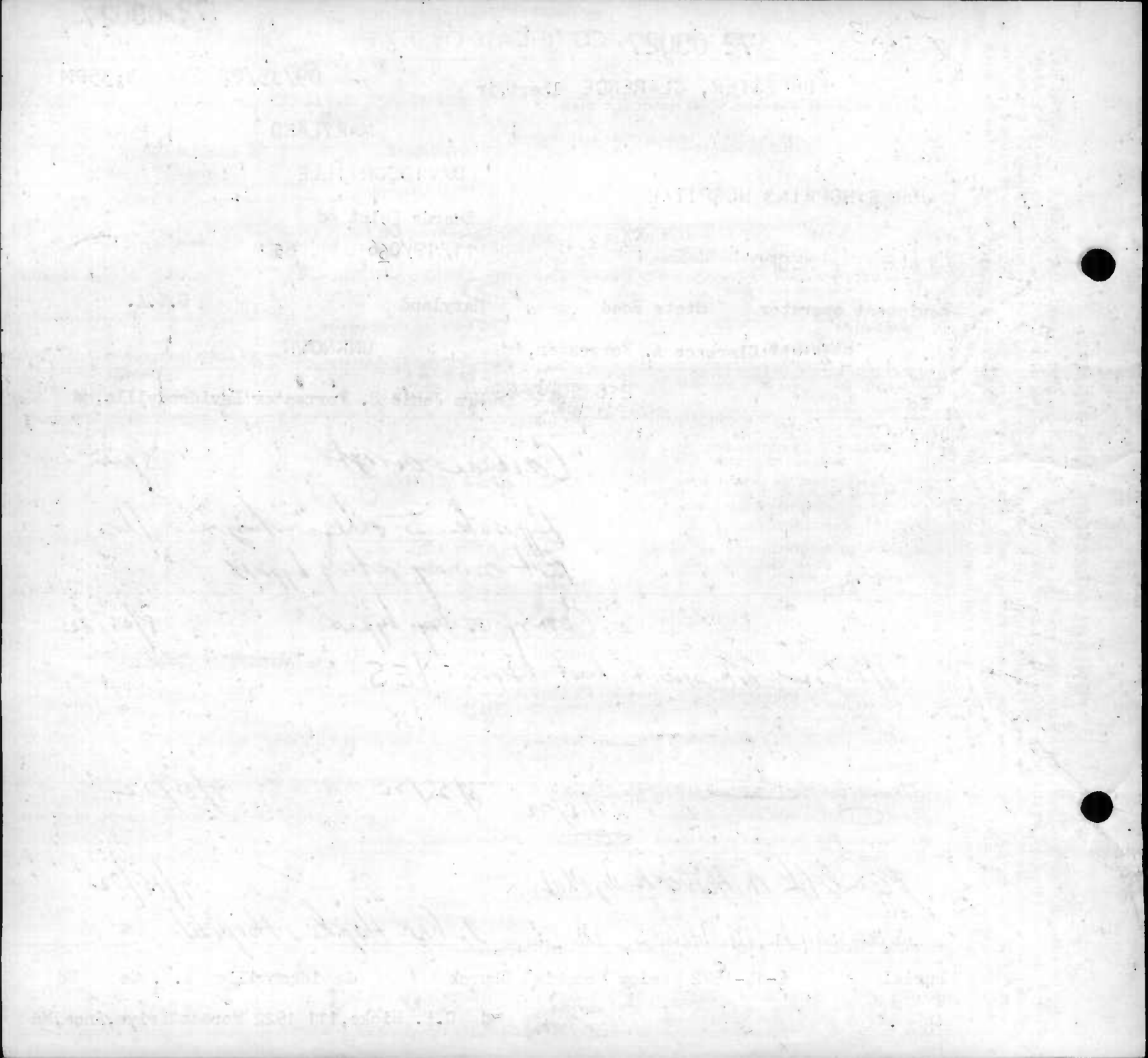
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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 09027		72 09027	
BIRTH NO. <b>7-623</b>		<b>CERTIFICATE OF DEATH</b>		REG. NO. <b>72 09027</b>	
1. NAME OF DECEASED (Type or Print) <b>FORRESTER, CLARENCE Albert, Jr</b>		2. DATE AND HOUR OF DEATH <b>09/15/72 3:35PM</b>		STATE OF MARYLAND - DEPT. OF HEALTH	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>JOHNS HOPKINS HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>5200</b>		C. CITY OR TOWN <b>DAVIDSONVILLE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>MALE</b>		6. RACE <b>NEGRO</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>11/17/06</b>		9. AGE (In years last birthday) <b>65</b>		10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Equipment operator</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>State Road</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>UNKNOWN Clarence A. Forrester, Sr</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-10-3569</b>		17. INFORMANT <b>Mrs Janie B. Forrester Davidsonville, Md</b>	
18. <b>41203 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) <b>Hypertension &amp; hemorrhage</b> (C) <b>Left coronary artery bypass</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Coronary artery bypass</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b> <b>1 hr.</b> <b>8/25/72</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>8/25/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>arterioblastic heart disease</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <del>this hospital</del> attended the deceased from <b>8/25/72</b> 19 to <b>9/15/72</b> 19, that (I) <del>we</del> last saw the deceased alive on <b>9/15/72</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <del>we</del> <b>did</b> (did not) view the body after death.					
23A. SIGNATURE <b>Randolph M. Hawes, M.D.</b>		23B. DATE SIGNED <b>9/15/72</b>		23C. PHYSICIAN'S NAME (Type) <b>Randolph M. Hawes, M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-19-1972</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Union Memorial Church</b>	
24D. LOCATION (City, town, or county) <b>Davidsonville A. Co Md</b>		24E. NAME OF REGISTRAR <b>U.E. Hicks</b>		24F. FUNERAL DIRECTOR <b>U.E. Hicks</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 21 1972</b>		25B. NAME OF REGISTRAR <b>Adrian Thornton</b>		25C. FUNERAL DIRECTOR <b>U.E. Hicks</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09028		72 09028		REG. NO. STATE OF MARYLAND-DEATH	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH					
LEWIS, William Brimage				September 18, 1972 6:30 A M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE		B. COUNTY		C. CITY OR TOWN	
Veterans Administration Hospital				Maryland				D. INSIDE CITY LIMITS?	
3900 Loch Raven Blvd				Baltimore				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Baltimore, Maryland 21218				E. STREET AND NUMBER		4012 Kathland Ave			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?		
Male	Negro	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10-1-40	31	Claim Adjuster	Washington D.C.	U.S.A.		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
William B. Lewis				Medieth Snowden					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT			
Yes				7-10-63 to 7-10-69		219-36-36-02		Records	
						VAH, 3900 Loch Raven Blvd., Balto., Md. 21218			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH					
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				CIRCULATORY Collapse					
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				METASTATIC Adenocarcinoma					
				(B) DUE TO, OR AS A CONSEQUENCE OF:					
				Carcinoma of Colon					
				(C) 3 mos					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				II					
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
5-8-72				Colon obstruction		No		No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
No									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (u) (this hospital) attended the deceased from September 12, 19 72 to September 18, 19 72, that (u) (we) last saw the deceased alive on September 18, 19 72 and that in (u) (our) opinion death occurred on the date and hour and from the causes stated above. (u) (We) (did) (not) view the body after death.									
23A. SIGNATURE						23B. DATE SIGNED			
Hugh Robinson M.D.						9-18-72			
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS			
Hugh Robinson M.D.						3900 Loch Raven Blvd., Balto., Md. 21218			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial				9-23-1972		Maryland National Memorial Pk Laurel		Md	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
SEP 21 1972				Lidney		C.E. Hicks, 111 263 W. Patrick St, Frederick		Md	

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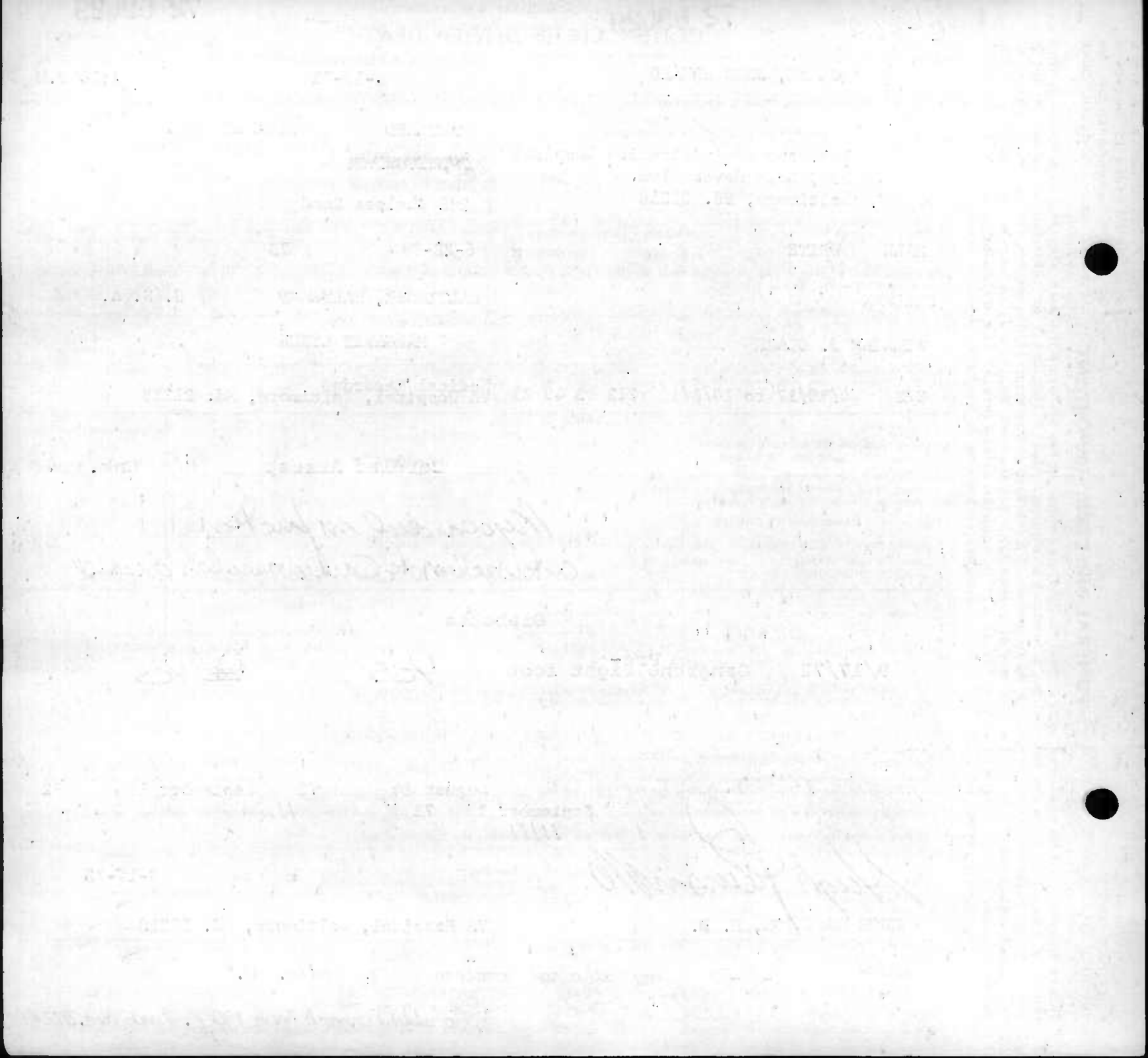
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

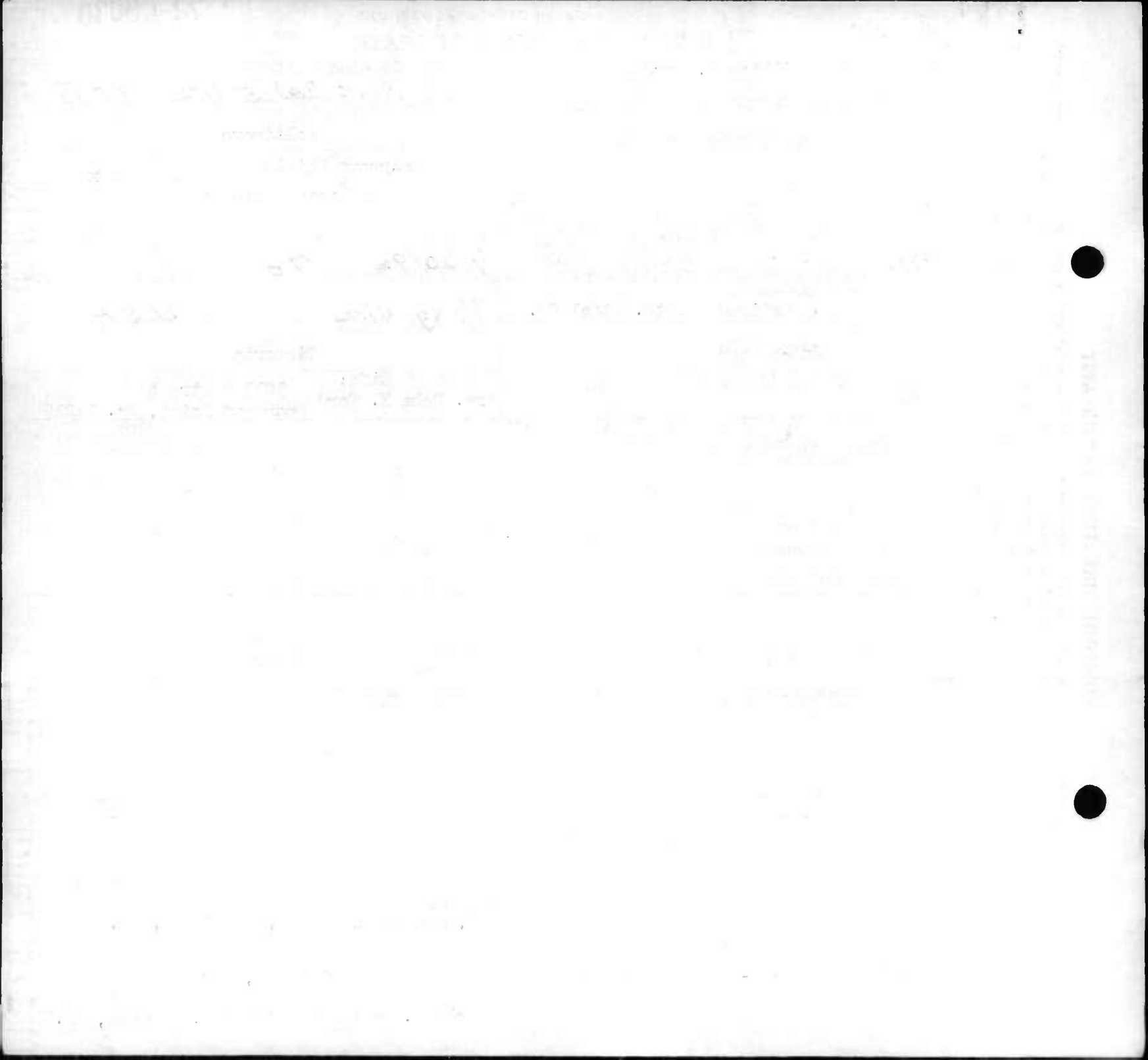
Baltimore City Health Department				72 09029		72 09029	
C-462				72 09029		72 09029	
BIRTH NO.				REG. NO.		STATE OF MARYLAND - DEATH	
1. NAME OF DECEASED (Type or Print) <b>CLARK, JOHN EDWARD</b>				2. DATE AND HOUR OF DEATH <b>9-19-72 1:30 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>23 Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Md. 21218</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>ANNE ARUNDEL</b> C. CITY OR TOWN <b>RIVIERA BEACH</b> D. INSIDE CITY LIMITS? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>208 Chelsea Road</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>6-28-99</b>	9. AGE (In years last birthday) <b>73</b>	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FIREMAN</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>WILLIAM J. CLARK</b>				14. MOTHER'S MAIDEN NAME <b>MARGARET LYNCH</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES 4/10/17 to 10/8/19</b>		16. SOCIAL SECURITY NO. <b>212 03 49 29</b>		17. INFORMANT ADDRESS <b>Medical Records VA Hospital, Baltimore, Md. 21218</b>			
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) <i>Myocardial infarction</i> (C) <i>atherosclerotic Cardiovascular disease</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Diabetes</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Unk.</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Diabetes</b>							
19A. DATE OF OPERATION <b>3 9/17/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Gangrene right foot</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>August 14 19 72</b> to <b>September 19 19 72</b> , that (I) (we) last saw the deceased alive on <b>September 19 19 72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Hugh Robinson M.D.</b>				23B. DATE SIGNED <b>9-19-72</b>			
23C. PHYSICIAN'S NAME (Type) <b>HUGH ROBINSON, M. D.</b>				23D. ADDRESS <b>VA Hospital, Baltimore, Md. 21218</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-22-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 21 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Robinson</b>		25C. FUNERAL DIRECTOR <b>McCully Funeral Home</b>		ADDRESS <b>130 E. Fort Ave. 21230</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										72 09030	
7-630 72 09030 CERTIFICATE OF DEATH										X REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>William H. Ford</u>										2. DATE AND HOUR OF DEATH <u>September 15 1972</u> <u>9.45</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Maryland General Hospital</u>										4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>48 Maryland General Hospital</u>										C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <u>1011 H Street</u>											
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/20/96</u>	9. AGE (In years last birthday) <u>76</u>	If Under 1 Yr. Months: Days: Hours: Min.						
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Beth. Steel Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>			12. CITIZEN OF WHAT COUNTRY <u>USA</u>			
13. FATHER'S NAME <u>James Ford</u>					14. MOTHER'S MAIDEN NAME <u>Victoria</u>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>216-10-5044</u>		17. INFORMANT <u>Wife:</u> <u>Mrs. Reba K. Ford</u>			ADDRESS <u>1011 H Street Sparrows Point, Md. 21219</u>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>(A) IMMEDIATE CAUSE Cerebral Thrombosis</u> <u>(B) HYPERTENSION + ARTERIO-SCLEROTIC</u> <u>(C) Cardiovascular Disease</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (A) (this hospital) attended the deceased from <u>9/15</u> 19 <u>72</u> to <u>9/15</u> 19 <u>72</u> that (B) (we) last saw the deceased alive on <u>9/15</u> 19 <u>72</u> and that (C) (my) (ap)ntial death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>George E. L. Brown MD</u>										23B. DATE SIGNED <u>9/15/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>DR Blazek</u>										23D. ADDRESS <u>Md. General Hospital, Baltimore, Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-19-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>			24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 21 1972</u>			25B. NAME OF REGISTRAR <u>Andrew Johnson</u>			25C. FUNERAL DIRECTOR <u>John J. Duda</u>			ADDRESS <u>7922 Wise Ave. Dundalk, Md. 21222</u>		

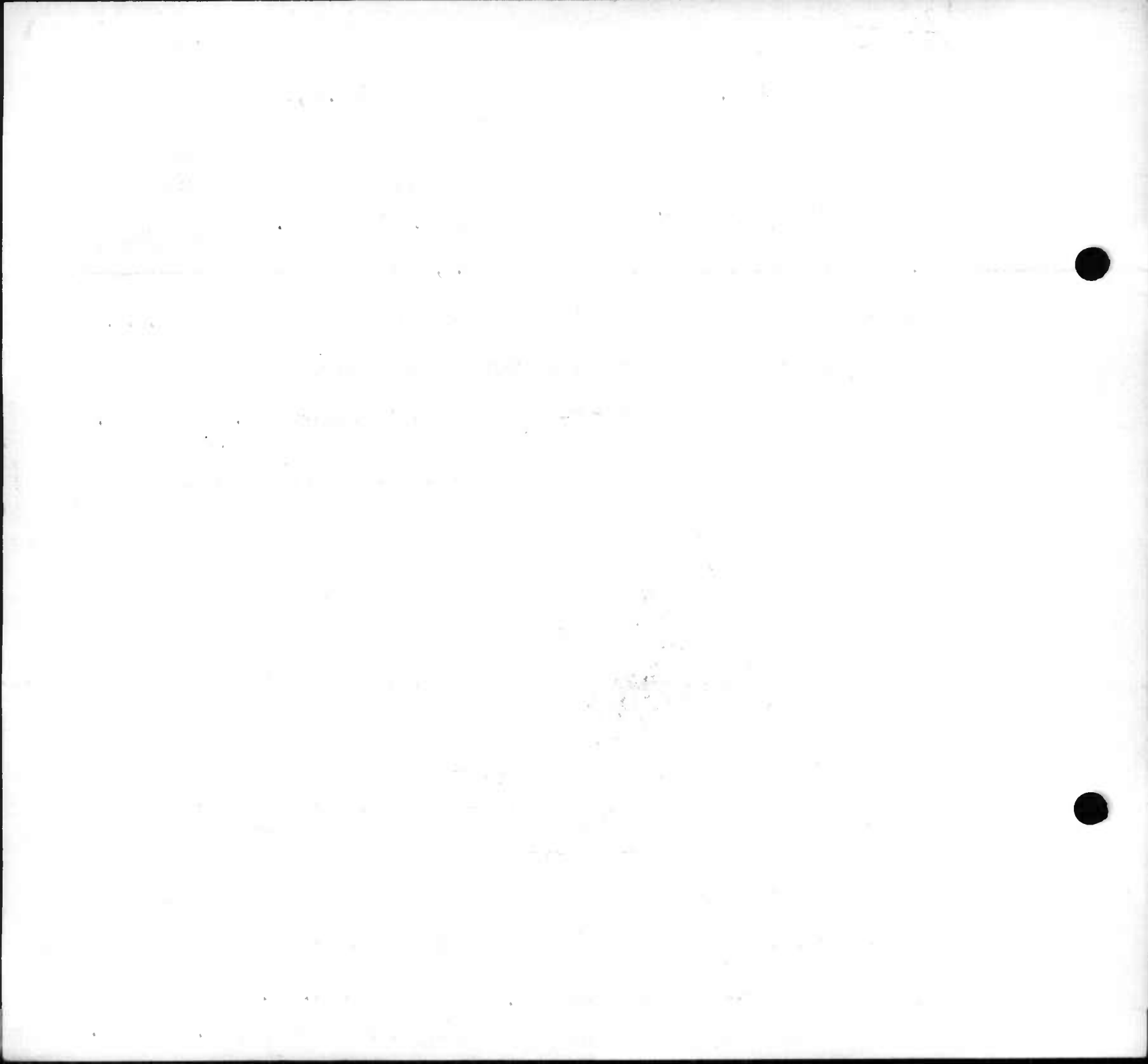




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 09031		REG. NO. 72 09031	
BIRTH NO. H-453		72 09031		STATE OF MARYLAND-DEMH	
1. NAME OF DECEASED (Type or Print) <i>Annie E. Holland</i>			2. DATE AND HOUR OF DEATH <i>Sept. 19, 1972 12:30 P.M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <i>1403 Patapsco St.</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2302</i>		
5. SEX <i>F.</i>			6. RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Jan. 9, 1893</i>		9. AGE (In years last birthday) <i>79</i>		10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
13. FATHER'S NAME <i>John Cox</i>			14. MOTHER'S MAIDEN NAME <i>Dora Koerner</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>213-10-6598 D</i>		17. INFORMANT <i>Margaret Hogenson</i>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <i>ARTERIO-SCLEROTIC AND HYPERTENSIVE CARDIO VASCULAR DISEASE</i>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>DIABETES MELLITUS.</i>					
19A. DATE OF OPERATION <i>9/20/72</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No.</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>9/21/72</i> 19 <i>72</i> to <i>9/19/72</i> 19 <i>72</i> that (I) <i>(we)</i> last saw the deceased alive on <i>9/21/72</i> 19 <i>72</i> and that in (my) <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>(we)</i> (did) <i>(did not)</i> view the body after death.					
23A. SIGNATURE <i>H.P. Friedman</i>			23B. DATE SIGNED <i>9/20/72</i>		23C. PHYSICIAN'S NAME (Type) <i>H.P. Friedman M.D.</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>9-23-72</i>		24C. NAME OF CEMETERY or CREMATORY <i>Holy Cross Cem.</i>
24D. LOCATION (City, town, or county) <i>Balto. Md.</i>			24E. ADDRESS <i>1319 Light St. Balto Md. 21230</i>		25A. DATE REC'D BY HEALTH DEPT. <i>SEP 21 1972</i>
25B. NAME OF REGISTRAR <i>Sidney W. Houston</i>			25C. FUNERAL DIRECTOR <i>McGully Funeral Home</i>		
25D. ADDRESS <i>130 E. Font Ave. 21230</i>					

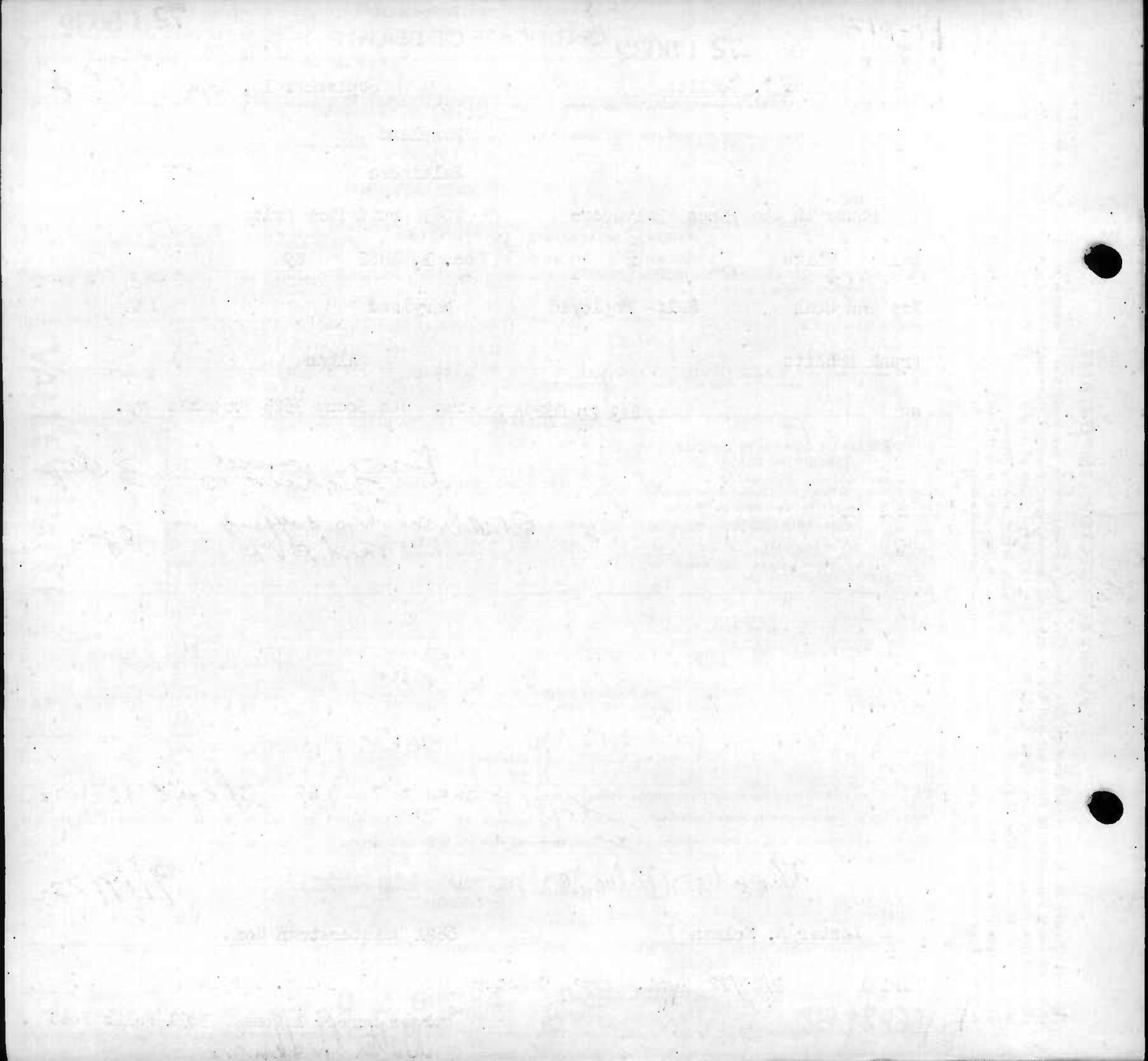




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">72 09032</span>	
B-143 72 09032				STATE OF MARYLAND-DEPT	
1. NAME OF DECEASED (Type or Print) <b>Walter F. Boblitz</b>		2. DATE AND HOUR OF DEATH <b>September 18, 1972</b> <span style="float: right;">4:00 A M.</span>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>90 House in the Pines Belvedere</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1338</b>			
FULL NAME OF HOSPITAL OR INSTITUTION  <b>90</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ice and Coal</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Self-Employed</b>		8. DATE OF BIRTH <b>Dec. 1, 1882</b> 9. AGE (In years last birthday) <b>89</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Frank Boblitz</b>		14. MOTHER'S MAIDEN NAME <b>Alban</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>213 20 0629A</b>		17. INFORMANT ADDRESS <b>Mrs. Ruth Boone 3525 Parkdale Ave.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>412.41</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Pneumonia</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Cerebral Onseffing</b> (C) <b>at 100</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Sept 27 1969</b> to <b>Sept 18 1972</b> , that (I) (we) last saw the deceased alive on <b>Sept 15 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Lester N. Kolman</b>				23B. DATE SIGNED <b>9/19/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Lester N. Kolman</b>				23D. ADDRESS <b>6821 Reisterstown Road</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/20/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>St. Mary's Cemetery (Hampton) Balto. Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 21 1972</b>		25B. NAME OF REGISTRAR <b>Walter J. Hens</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Burgess Funeral Home 3631 Falls Road</b>	



# FUNERAL DIRECTOR: IMPORTANT

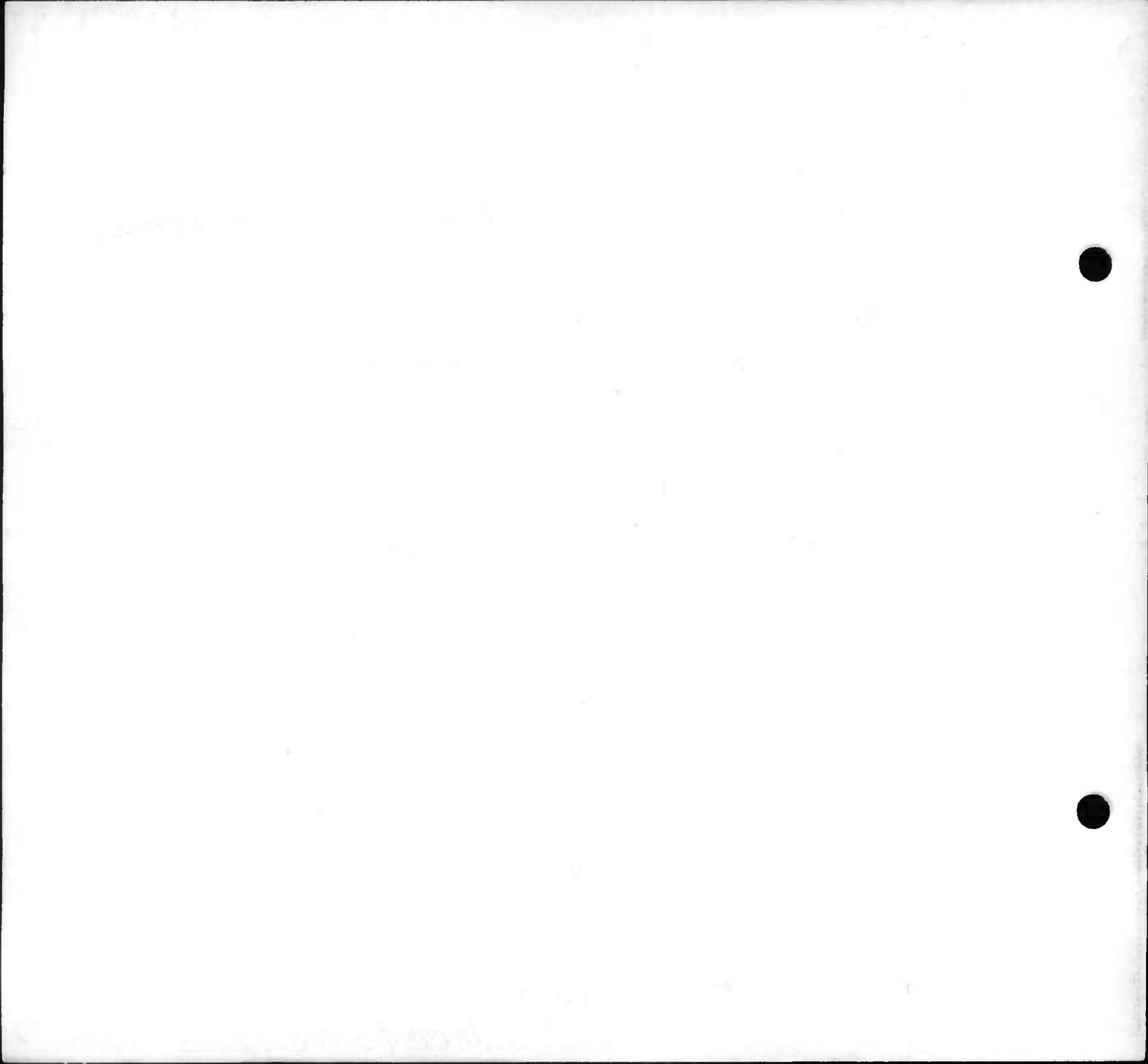
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09033		72 09033	
CERTIFICATE OF DEATH				REG. NO.		STATE OF MARYLAND-DHMH	
BIRTH NO. <u>D-120</u>				DATE AND HOUR OF DEATH <u>11:50 AM, Sept 17 '72</u>			
1. NAME OF DECEASED (Type or Print) <u>DAVIS, Harry M.</u>				2. DATE AND HOUR OF DEATH			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>U.M.H. UNION MEMORIAL HOSPITAL</u>				A. STATE <u>MARYLAND</u>		B. COUNTY <u>1307</u>	
				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>1014 UNION AVE</u>			
5. SEX <u>M</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/28/79</u>	9. AGE (In years last birthday) <u>93</u>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FLOOR FINISHER</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>RESIDENTIAL</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>012-024251A</u>		17. INFORMANT <u>ROMAYNE Chilcoat</u> ADDRESS <u>1014 UNION AVE</u>	
18. <u>433.7 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Central failure</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u>	
				(B) <u>CDA = multiple vascular occlusion 4 days</u> DUE TO, OR AS A CONSEQUENCE OF:			
				(C) <u>Atherosclerosis</u>		<u>Several yrs.</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Old aged</u>							
19A. DATE OF OPERATION <u>9/16/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>pt. Branch a. occlusion</u>		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Sept 14</u> 19 <u>72</u> to <u>Sept 17</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>Sept 17</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Chiau-Wen Hsiao, M.D.</u> DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>Sept. 17 '72</u>	
23C. PHYSICIAN'S NAME (Type) <u>CHIAU-WEN HSIAO</u> DEGREE				23D. ADDRESS <u>U. M. H.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>9/20/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>MORELAND MEM. PARK</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO. CO. MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 21 1972</u>		25B. NAME OF REGISTRAR <u>Frederick H. H. H.</u>		25C. FUNERAL DIRECTOR <u>BURGEE FEDERAL HOME</u>		ADDRESS <u>13631 FAIR RD</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

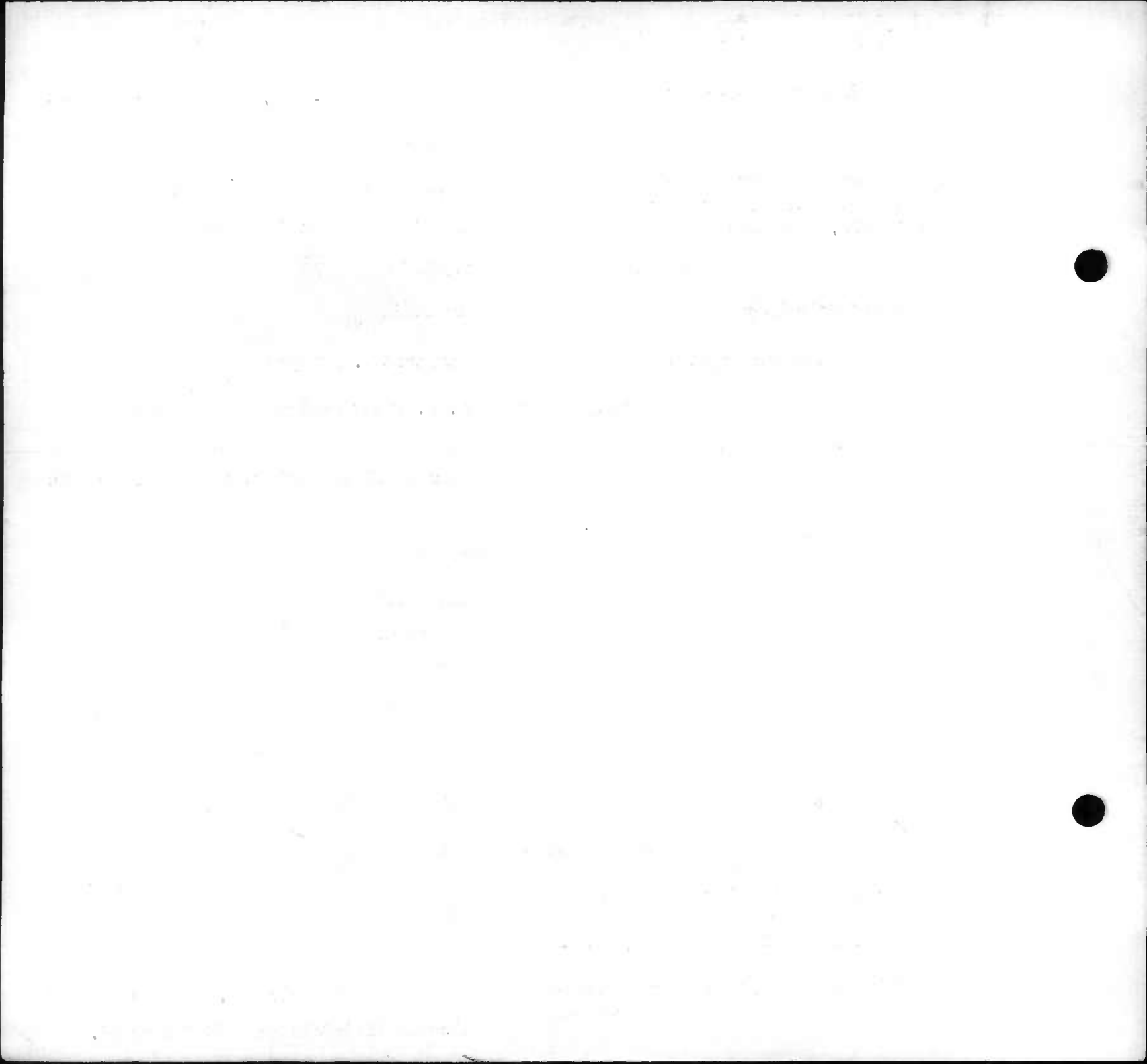
S-314		72 09034		BALTIMORE CITY HEALTH DEPARTMENT		72 09034	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.		STATE OF MARYLAND-DEATH	
1. NAME OF DECEASED (Type or Print) <u>PHILIP F. STIFFLER</u>				2. DATE AND HOUR OF DEATH <u>9-18-72</u> <u>2:20 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>LUTHERAN HOSPITAL OF MARYLAND</u>				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1306</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3542 ROLAND AVENUE</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-7-83</u>	9. AGE (in years last birthday) <u>89 y.</u>	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LINE MAN</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>CIP TELEPHONE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Edward Stiffler</u>				14. MOTHER'S MAIDEN NAME <u>KATHERINE KAZAR</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212 05 0909</u>		17. INFORMANT <u>HILDA REEVES 3133 CR. HENTON PLACE</u>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Septicemia</u> <u>Pneumonia</u> <u>Serum Sickness</u> <u>Autemoseptic shock</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <u>0 - -</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>-</u>			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>-</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>-</u>			
22. I certify that (I) (this hospital) attended the deceased from <u>9-17</u> 19 <u>72</u> to <u>0-18</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>9-18</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>[Signature]</u> M.D. DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>9-18-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>M. A. ANWAR</u> M.D. DEGREE				23D. ADDRESS <u>Lutheran Hospital of Maryland</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>9/24/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>ST MARKS CEMETERY</u>		24D. LOCATION (City, town, or county) (State) <u>S. HANOVER MD</u>	
25A. DATE RECEIVED BY HEALTH DEPT. <u>SEP 21 1972</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>BURGETT F. FUNK</u> ADDRESS <u>3131 FALK RD</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

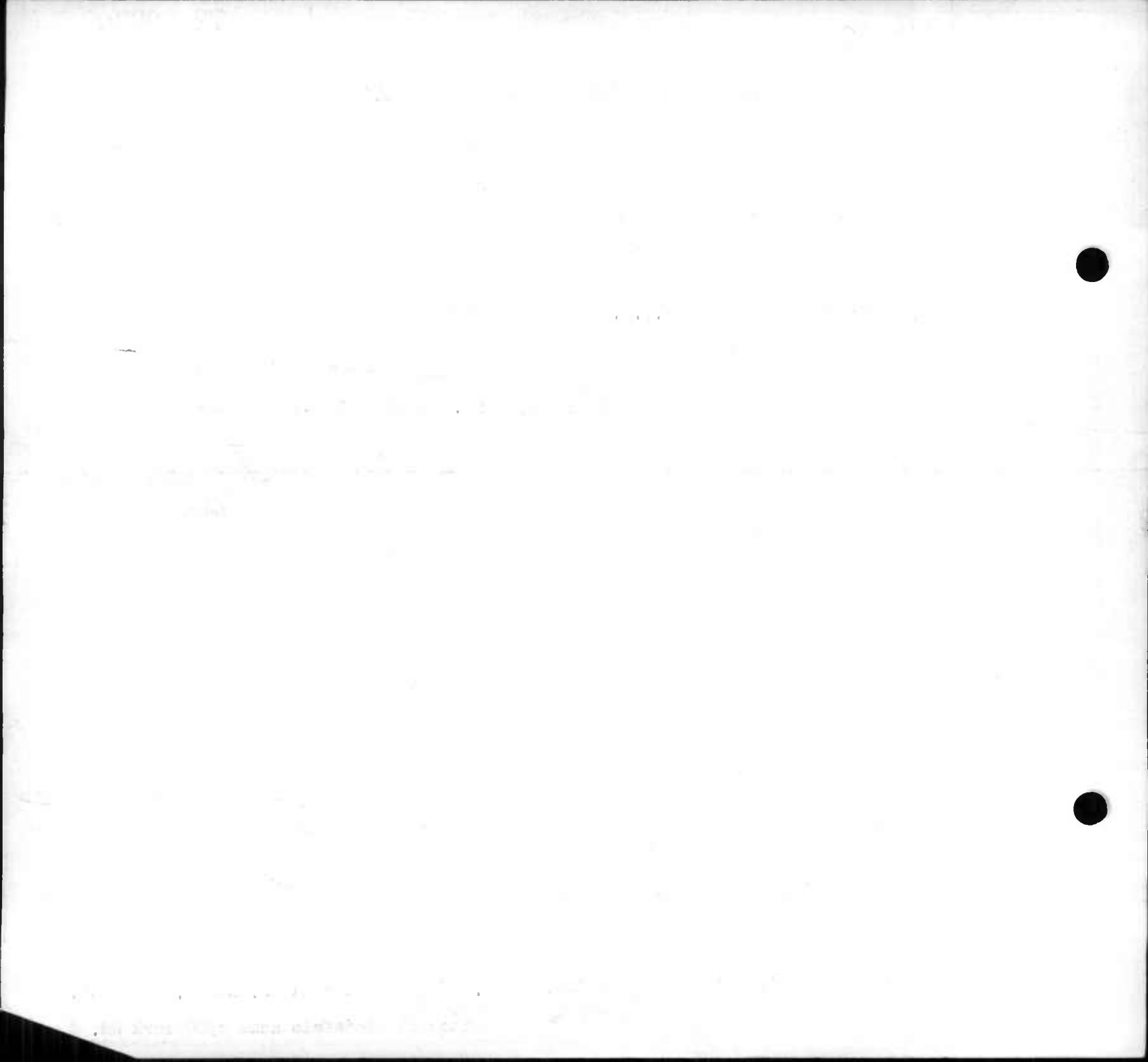
BALTIMORE CITY HEALTH DEPARTMENT 72 09035 CERTIFICATE OF DEATH				REG. NO. 72 09035	
BIRTH NO. <u>M-540</u>		1. NAME OF DECEASED (Type or Print) <u>Elizabeth Manley</u>		2. DATE AND HOUR OF DEATH <u>Sept. 17, 1972</u> <u>11:45 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>THE GOOD SAMARITAN HOSPITAL</u> <u>5601 Loch Raven Boulevard</u> <u>Baltimore, Maryland</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2758</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1679 Northern Parkway</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/7/1899</u>	9. AGE (In years last birthday) <u>73</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Saleslady</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>Charles Royston</u>			14. MOTHER'S MAIDEN NAME <u>Margaret A. Peregoy</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218229800</u>	17. INFORMANT <u>Mr. J. Frank Manley</u>		ADDRESS <u>Same</u>
18. <u>182294213019</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cancer of the uterus</u> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>19 years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			<u>Diabetes mellitus</u>		
19A. DATE OF OPERATION <u>9/17/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>the</del> (this hospital) attended the deceased from <u>9/7/72</u> 19 to <u>9/17/72</u> 19 that <del>we</del> (we) last saw the deceased alive on <u>9/17/72</u> 19 and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>(I)</del> (We) (did) <del>(did not)</del> view the body after death.					
23A. SIGNATURE <u>Michael Colvin, M.D.</u>				23B. DATE SIGNED <u>17 Sept 72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Michael Colvin</u>				23D. ADDRESS <u>Good Samaritan Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/20/1972</u>		24C. NAME of CEMETERY or CREMATORY <u>New Cathedral Cemetery</u>	
				24D. LOCATION (City, town, or county) (State) <u>Frederick Rd. Balto Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 21 1972</u>		25B. NAME OF REGISTRAR <u>Lidney Johnston</u>		25C. FUNERAL DIRECTOR <u>Mitchell Wiedefeld Home</u>	
				ADDRESS <u>6500 York Rd.</u>	





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W-422		72 09036		BALTIMORE CITY HEALTH DEPARTMENT		72 09036	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>WILLIAM J. WILKES</u>				2. DATE AND HOUR OF DEATH <u>17 Sept. 1972 11<sup>15</sup></u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>45 Good Samaritan</u>				A. STATE <u>MARYLAND</u> B. COUNTY <u>MONTGOMERY</u>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>Rockville</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>15004 COLUMBINE WAY</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-27-37</u>	9. AGE (In years last birthday) <u>34</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mgr. Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>I.B.M.</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>RALPH WILKES</u>				14. MOTHER'S MAIDEN NAME <u>ELEANOR JUDD</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>061 32 0433</u>		17. INFORMANT <u>Mrs. Marilyn Wilkes</u>		ADDRESS <u>same</u>	
18. <u>33371</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Creutzfeldt-Jakobs</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>DISEASE</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:  (C) 			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH Infolly medical examined <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>8/17</u> 19 <u>72</u> to <u>17 Sept</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>17 Sept</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Michael Colvin MD</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>18 Sept. 72</u>	
23C. PHYSICIAN'S NAME (Type) <u>MICHAEL COLVIN MD</u>				23D. ADDRESS <u>Good Samaritan Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/20/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Dulaney Valley Mem. Gds</u>		24D. LOCATION (City, town, or county) (State) <u>Padonia Rd. Balto. Md.</u>	
25A. DATE RECEIVED BY HEALTH DEPT. <u>SEP 21 1972</u>		25B. NAME OF REGISTRAR <u>Shirley H. H. H.</u>		25C. FUNERAL DIRECTOR <u>Mitchell Wiedefeld Home</u>			
				ADDRESS <u>6500 York Rd</u>			



# FUNERAL DIRECTOR: IMPORTANT

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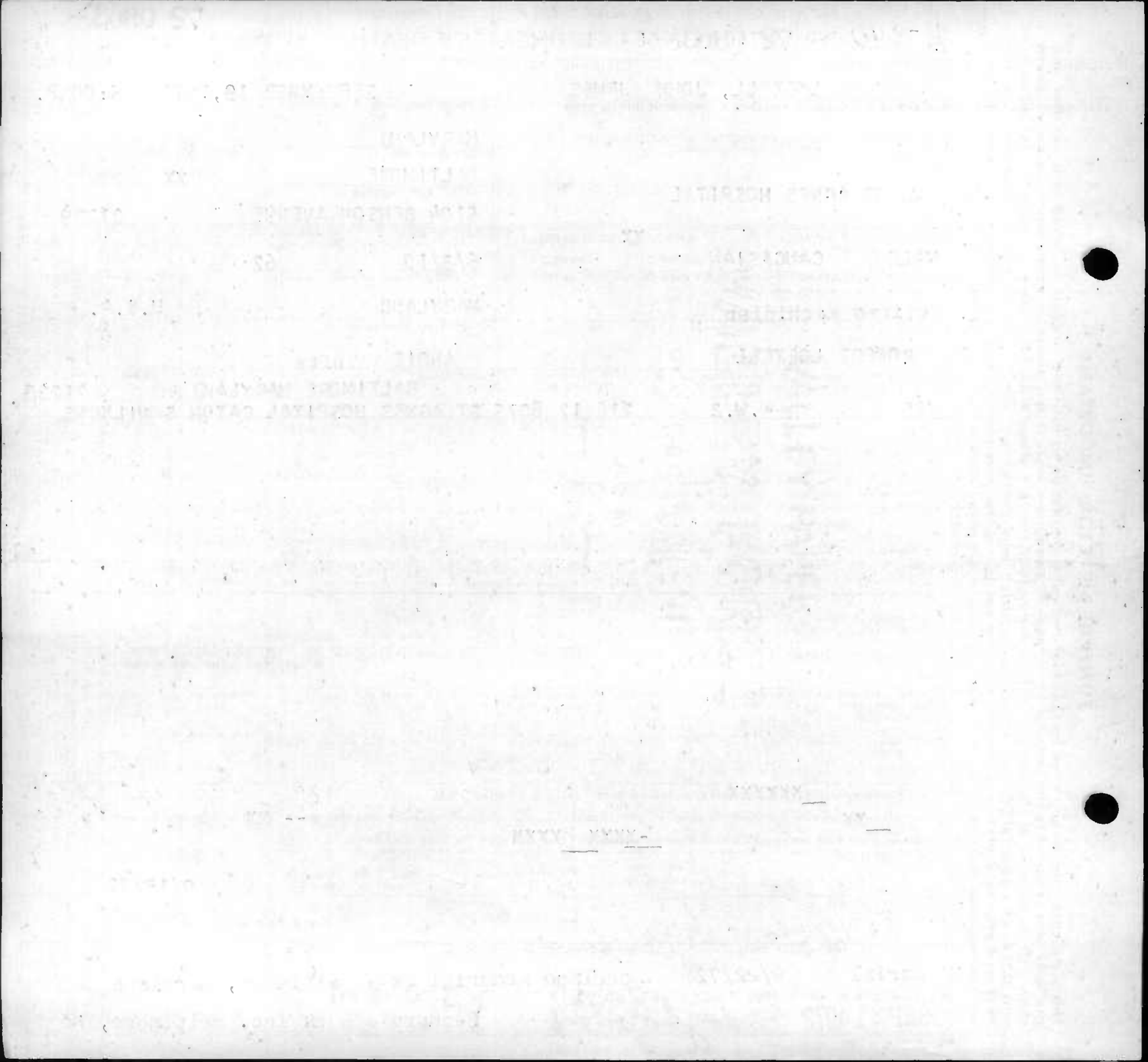
BALTIMORE CITY HEALTH DEPARTMENT				72 09037		REG. NO. 72 09037	
BIRTH NO. B-520				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Gladys L. Bemis				9/18/1972			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
00 116 W. University Pkw				Md. Balto 1201			
5. SEX				6. RACE			
Female				White			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				8. DATE OF BIRTH			
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				Jan. 15, 1907			
9. AGE (In years last birthday)				65			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)			
Practical Nurse				N.Y.			
10B. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY?			
Nursing				USA			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Orville F. Weegar				Calla A. Alden			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				105 14 2204			
17. INFORMANT				ADDRESS			
				Mrs. Mildred R. Maus 405 Burbank Ct.			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CVA			
DUE TO, OR AS A CONSEQUENCE OF:				immediate			
ANTECEDENT CAUSES				(B) Hypertensive ASCVD			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____				yrs			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.)				21E. HOW DID INJURY OCCUR?			
21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from 1/5/72 19 to 9/18/72 19 that (I) (we) last saw the deceased alive on 6/14/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Francis W. Gloor				9/14/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
				100 W. University Pkwy			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE			
Cremation				9/20/72			
24C. NAME OF CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)			
Greenmount Crematory				Greenmount Ave Balto Md.			
25A. DATE REC'D BY HEALTH DEPT				25B. NAME OF REGISTRAR			
SEP 21 1972				25C. FUNERAL DIRECTOR			
				ADDRESS			
				Mitchell Wiedefeld Home 6500 York Rd.			

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# FUNERAL DIRECTOR: IMPORTANT

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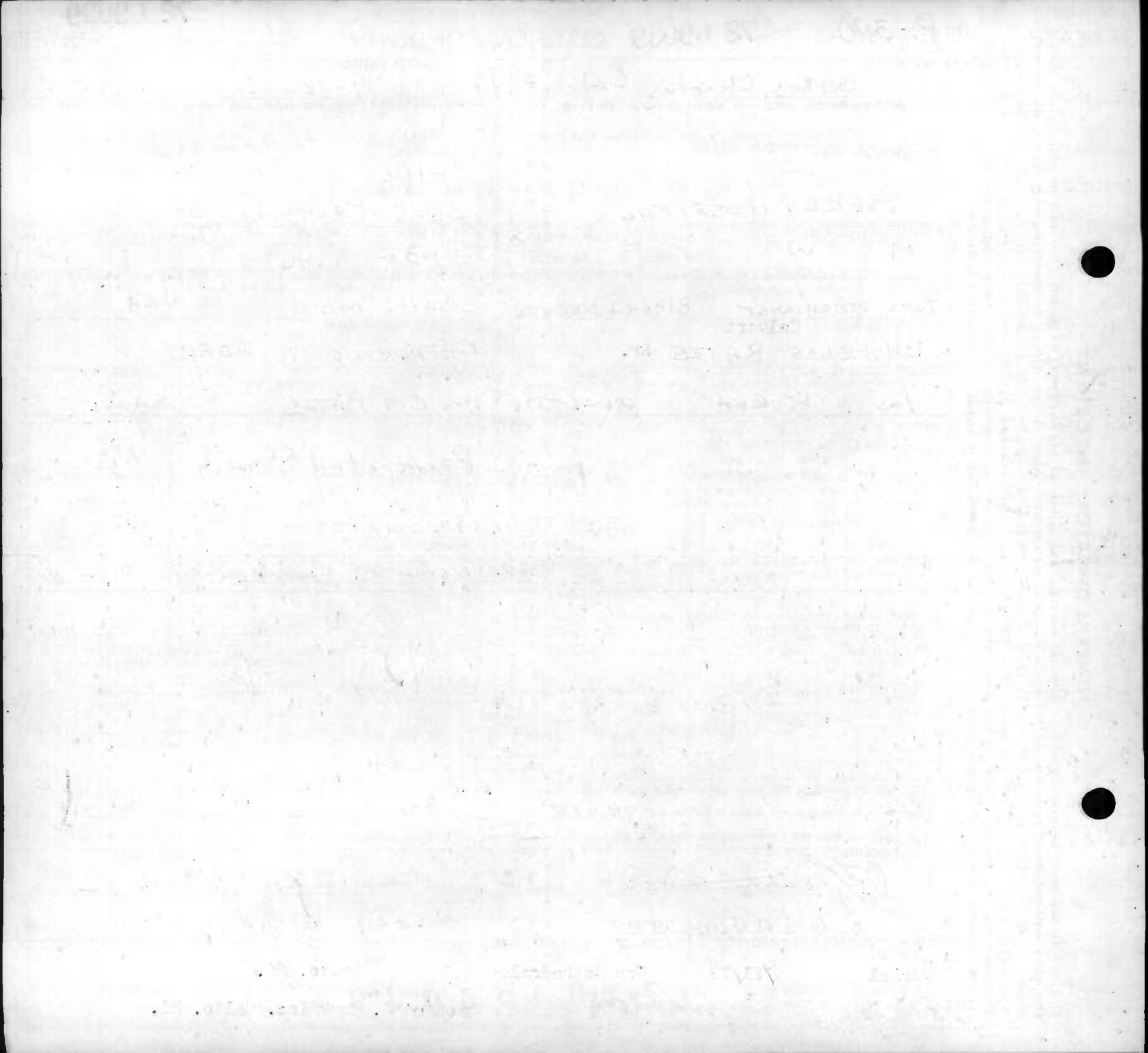
L-340 72 09038		BALTIMORE CITY HEALTH DEPARTMENT		72 09038
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.
1. NAME OF DECEASED (Type or Print) <b>LOETELL, JOHN JAMES</b>		2. DATE AND HOUR OF DEATH <b>SEPTEMBER 19, 1972 5:00 P. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>40 ST AGNES HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTO</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>5104 BENSON AVENUE 21229</b>		
5. SEX <b>MALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/3/10</b>	9. AGE (In years last birthday) <b>62</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Machinist</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>ROBERT LOETELL</b>		
14. MOTHER'S MAIDEN NAME <b>ANNIE Tufts</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, na or unknown) (If yes, give war or dates of service) <b>YES W.W.2</b>		
16. SOCIAL SECURITY NO. <b>216 12 8075</b>		17. INFORMANT <b>BALTIMORE MARYLAND 21229</b>		
18. <b>25 0.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>PREMIA</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>K-W Kidney and Pyelonephritis</b> <b>DIA Beta Mellitus</b>		19. CAUSE OF DEATH <b>7 days</b> <b>years</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) <del>the hospital</del> attended the deceased from <b>February 1972</b> to <b>Sept. 19 1972</b> , that (I) <del>we</del> last saw the deceased alive on <b>Sept 19 1972</b> and that in <del>my</del> <b>my</b> opinion death occurred on the date and hour and from the causes stated above, <b>XXXXX</b> <del>XXXX</del> <b>XXXX</b> view the body after death.				
23A. SIGNATURE <b>Alejandro Lucie</b>		23B. DATE SIGNED <b>9/19/72</b>		23C. PHYSICIAN'S NAME (Type) <b>ALEJANDRO MEJIA MD.</b>
23D. ADDRESS <b>St Agnes Medical Center</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		
24B. DATE <b>9/22/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Moreland Memorial Pk.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 21 1972</b>		25B. NAME OF REGISTRAR <b>Audrey Johnson</b>		25C. FUNERAL DIRECTOR <b>Leonard J Ruck Inc. Baltimore, Md</b>



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				72 09039		72 09039	
BIRTH NO. B-320				72 09039		72 09039	
1. NAME OF DECEASED (Type or Print) <b>Bates, Charles Calvert Jr</b>				2. DATE AND HOUR OF DEATH <b>9-18-72 12:25 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>37 MERCY HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>2731</b>			
5. SEX <b>M</b> 6. RACE <b>W</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>1-14-32</b>		9. AGE (In years last birthday) <b>40</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TOOL MACHINIST</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>BLACK &amp; DECKER</b>		11. BIRTHPLACE (State or foreign country) <b>Balto MD</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Calvert CHARLES BATES Sr.</b>			
14. MOTHER'S MAIDEN NAME <b>CATHERINE V. ADER</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes KOREA</b>			
16. SOCIAL SECURITY NO. <b>216-28-0376</b>				17. INFORMANT <b>Mrs C.V. BATES</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Perforated Stomach</b> (B) <b>CARCINOMATOSIS</b> (C) <b>CARCINOMA At upper lobe lung</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>hrs</b> <b>wks</b> <b>mos-yrs</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>2</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>				21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from <b>9-10-1972</b> to <b>9-18-1972</b> , that (we) lost saw the deceased alive on <b>9-18-1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>[Signature]</b>				23B. DATE SIGNED <b>9-18-72</b>		23C. PHYSICIAN'S NAME (Type) <b>R. G. LANCASTER</b>	
23D. ADDRESS <b>MERCY Hospital</b>				24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>9/21/72</b>				24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 21 1972</b>				25B. NAME OF REGISTRAR <b>[Signature]</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Balto. Md.</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09040	
72 09040				STATE OF MARYLAND DEATH	
BIRTH NO. L-250		NAME OF DECEASED (Type or Print) ELIZABETH FLETCHER LOGAN		2. DATE AND HOUR OF DEATH 9-19-72 4:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 2037	
FULL NAME OF HOSPITAL OR INSTITUTION 131 N. MONASTORY AVE		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTO D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F. 6. RACE Col		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH 9-15-1900 9. AGE (In years last birthday) 72	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) Henrico Co. VA 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GABRIEL JOHNSON		14. MOTHER'S MAIDEN NAME UNKNOWN ADELAID PARR			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Mary BROWN 131 N. Monastory	
18. 41221 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Hypertensive Artherosclerotic Cardiovascular Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) None	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 1972 to Sept 1972, that (I) (we) lost saw the deceased alive on 18 Sept 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Alva S. Baker, M.D.				23B. DATE SIGNED 19 Sept 1972	
23C. PHYSICIAN'S NAME (Type) Alva S. Baker, M.D.				23D. ADDRESS University of Maryland Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/22/73		24C. NAME OF CEMETERY or CREMATORY BALTO NATIONAL BALTO MD	
25A. DATE REC'D BY HEALTH DEPT SEP 21 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
				ADDRESS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 09041		72 09041	
K-656		72 09041		72 09041	
BIRTH NO.		72 09041		72 09041	
1. NAME OF DECEASED (Type or Print)		EVA KRAMER		2. DATE AND HOUR OF DEATH Sept 17 1972 4:30 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD.		B. COUNTY 2401	
FULL NAME OF HOSPITAL OR INSTITUTION 90 CERTIFICATE AMENDED EDGEWOOD NURSING HOME 10-4-72		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 7-16-86		9. AGE (In years last birthday) 86		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Austria	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Henry AUBERMANN		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-05-9459		17. INFORMANT Helen Copper 624 E. Fort Avenue	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mos	
		(B) Carcinoma of Hypopharynx DUE TO, OR AS A CONSEQUENCE OF:		?	
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Arteriosclerotic CVD disease				5+ yrs	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (the hospital) attended the deceased from Sept 9, 1972 to Sept 17, 1972 that (I) (we) last saw the deceased alive on Sept 10, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Frederick J. Vollmer MD		23B. DATE SIGNED 9-17-72		23C. PHYSICIAN'S NAME (Type) FREDERICK J. VOLLMER MD	
23D. ADDRESS 6100 York Rd Balto Md 21212		24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 9/20/72	
24C. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		24D. LOCATION (City, town, or county) BALTIMORE, Maryland		24E. STATE MD	
25A. DATE REC'D BY HEALTH DEPT SEP 21 1972		25B. NAME OF REGISTRAR Friedrich W. W. W.		25C. FUNERAL DIRECTOR CHARLES L. STEVENS Funeral Home, Inc. 1501 EAST FORT AVENUE	

10-4-1972 - Correction Form from Funeral Home - Charles L. Stevens Funeral Home, Inc.  
Balto., Md. HRS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 09042	
S-625		72 09042	
BIRTH NO.		72 09042	
1. NAME OF DECEASED (Type or Print) <u>Szerksen Alexandre</u>		2. DATE AND HOUR OF DEATH <u>9/20/72</u> <u>11.40 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>CHURCH HOME &amp; HOSPITAL</u> <u>100 N. Broad way BALT. MD.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>105</u>	
5. SEX <u>F</u> 6. RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <u>STANLEY WUTK</u>		14. MOTHER'S MAIDEN NAME <u>ANNA OLECZUKI</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-10-1804</u>	
17. INFORMANT <u>HELEN</u> ADDRESS <u>med. center</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMER</u>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>G.I. bleeding</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>+ Cor. A. Cause Unknown</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Probable C.V.A.</u>	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 day</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9/20/72</u> 19 <u>72</u> to <u>9/20</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>9/20</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>D. R. Antara</u>		23B. DATE SIGNED <u>9/20/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>D. J. R. ANTARA</u>		23D. ADDRESS <u>CHURCH HOME &amp; HOSPITAL</u> <u>100 N. Broadway</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>9-23-72</u>	
24C. NAME OF CEMETERY or CREMATORY <u>HOLY ROSARY SEM.</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 21 1972</u>		25B. NAME OF REGISTRAR <u>Arlene Johnson</u>	
25C. FUNERAL DIRECTOR <u>JOHN A. WEBER &amp; SONS INC.</u>		25D. ADDRESS <u>4015 CHESTER</u>	

20415 W. WEBERSON

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 09043		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09043	
<b>CERTIFICATE OF DEATH</b>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ANNA LORINCE		9/19/72 1:00 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
HOUSE IN THE PINES-BELAIR 5837 BELAIR RD. BALTO., MD.		MD		2605	
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
FEMALE		WHITE		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH		9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
SEPT. 16, 1886		86		RETIRED	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
CZECHOSLOVAKIA		U. S. A.		GEORGE SAXON	
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
ELIZABETH ?		NO		213-74-4115	
17. INFORMANT		ADDRESS			
JOSEPH LAWRENCE		404 JOPLIN ST. #21224			
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Arteriosclerotic Heart Disease			
(B) Contributing Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF:		years			
(C)					
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		II			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Recent Pneumonia, Chronic Brain Syndrome			
20. ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (the hospital) attended the deceased from 9/19/72 to 9/19/1972 that (I) (we) last saw the deceased alive on 9/16/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
Albert B. Bradley		9/19/72		ALBERT B. BRADLEY	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		9-23-72		OAK LAWN CEM.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
SEP 21 1972		Sidney H. Weston		Charles S. Gailer	
				ADDRESS 6224 EASTERN AVE. BALTO., 21224, MD.	

FEMALE WHITE  
 \*  
 SEPT 16 1886 86  
 440 CORNWALL ST BALTIMORE  
 HOUSE IN THE PINES-BELAIR BALTIMORE  
 2837 BELAIR RD.  
 BALTO, MD  
 MD

NO ——— 212 34 412 7-11  
 GEORGE Saxon  
 ELIZABETH  
 RETIRED HOUSE WORK  
 CECILIA  
 U.S.A.

ALBERT B. BRATLEY 440 BELAIR RD BALTO

Charles & John



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09044	
C-650 72 09044				STATE OF MARYLAND - DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) CURRAN, JOSEPH IGNATIUS			
2. DATE AND HOUR OF DEATH		SEPTEMBER 15, 1972 3:50PM.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
ST. AGNES HOSPITAL		MD. BALTIMORE			
WILKENS & CATON AVENUES		C. CITY OR TOWN D. INSIDE CITY LIMITS?			
BALTIMORE, MARYLAND 21229		BALTIMORE YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER		1728 ARLINGTON AVENUE			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
MALE	CAUCASIAN	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	10-23-85	86	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
PLUMBER		SELF-EMPLOYED		MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
JOSEPH I. CURRAN		Elizabeth C. Williamson		U.S.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		217-32-8682		ST. AGNES HOSPITAL MEDICAL RECORDS	
18. 412.4 14-185X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		C. H. F. atherosclerotic Cardiovascular disease + adenocarcinoma of prostate and metastatic carcinoma			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (X) (this hospital) attended the deceased from AUGUST 24 1972 to SEPTEMBER 15 1972, that (X) (we) last saw the deceased alive on SEPTEMBER 15 1972 and that in (XXX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXXX) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Ferey Doun M.D.				9 15 72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
DEHKHAREGHANI, FEREYDOUN, M.D.				ST. AGNES HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		9-18-72		New Cathedral	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
SEP 21 1972		A. H. Hubbard		Howard H. Hubbard-4107 Wilkens Ave. 21229	

SEPTEMBER 12, 1971

ST. ANNE'S HOSPITAL

BALTIMORE, MD

BALTIMORE

1728 WASHINGTON AVENUE

ST. ANNE'S HOSPITAL

BALTIMORE, MARYLAND 21206

10-23-82

MALE CAUCASIAN

SELF-EMPLOYED

PLUMBER

MARYLAND

ELIZABETH C. WILLIAMSON

JOSEPH J. CURRAN

217-32-8682 ST. ANNE'S HOSPITAL MEDICAL RECORDS

NO

SEPTEMBER 12, 1971

AUGUST 28

SEPTEMBER 12, 72

XXXXX

ST. ANNE'S HOSPITAL

DEKINBERG, FREDYOUN, M.D.

THE CARDIOLOGIST

11-11-72

RECEIVED: 11-11-72

RECORDS SECTION - 11-11-72

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09045	
BIRTH NO. K-400		72 09045		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) KELLY, MARCUS JOHN			2. DATE AND HOUR OF DEATH SEPTEMBER 16, 1972 5:00 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST. AGNES HOSPITAL WILKENS & CATON AVENUES BALTIMORE, MARYLAND 21229			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3039 FREEWAY 21227		
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 03 29 29	9. AGE (In years last birthday) 43	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COMPUTER OPERATOR
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COMPUTER OPERATOR			10B. KIND OF BUSINESS OR INDUSTRY STEEL		11. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME MARCUS MICHAEL KELLY			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 215286238		
17. INFORMANT WILKENS AVE. BALTIMORE, MD. 21229			18. CAUSE OF DEATH		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) HEPATIC COMA CIRRHOSIS OF THE LIVER			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from SEPTEMBER 11, 1972 to SEPTEMBER 16, 1972, that (X) (we) last saw the deceased alive on SEPTEMBER 16, 1972 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXX) view the body after death.					
23A. SIGNATURE E. G. Romero MD				23B. DATE SIGNED 09 16 72	
23C. PHYSICIAN'S NAME (Type) E. G. ROMERO M.D.				23D. ADDRESS ST. AGNES HOSPITAL-CATON & WILKENS AVE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-19-1972		24C. NAME OF CEMETERY or CREMATORY Meadowridge Cemetery	
24D. LOCATION (City, town, or county) (State) Wash. Blvd. Howard Co., Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 21 1972			
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229			

KELLY, MARCUS JOHN

SEPTEMBER 18, 1972

MARYLAND

BALTIMORE

ST. AGNES HOSPITAL

ST. AGNES HOSPITAL

WICKES & CATON AVENUE  
BALTIMORE, MARYLAND 21229

DATE CAUCASIAN

KX 03 29 29

COMPUTER OPERATOR STEEL

MARYLAND

MARCUS MICHAEL KELLY

RUTH STAMM

WICKES AVE, BALTIMORE, MD 21229  
212290330 ST AGNES HOSPITAL RECORD-CATON &

YES

SEPTEMBER 11

SEPTEMBER 18

XX

XXX

X

ST. AGNES HOSPITAL CATON & WICKES AVE

F. A. KOWRO M.D.

WATER-PROOF PHOTOGRAPHY COMPANY

NOTARY

CSA

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09046		72 09046	
BIRTH NO.				72 09046		REG. NO.	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
LUMSDEN, ELVA PAULINE				SEPTEMBER 16, 1972 7:20 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL				A. STATE MARYLAND			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				B. COUNTY			
				C. CITY OR TOWN BALTIMORE			
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER 458 S BENTALOU STREET - 21223			
5. SEX FEMALE		6. RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/12/99	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 72		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME RICHARD NICHOLS		14. MOTHER'S MAIDEN NAME LILLIAN LYDDARD		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212 03 2285		17. INFORMANT ST AGNES HOSPITAL RECORDS CATON & WILKENS AVES BALTO MD 21229		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 192.9 I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE Glycyloma DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <u>XX</u> (this hospital) attended the deceased from <u>08/25/1972</u> to <u>09/16/1972</u> , that <u>XX</u> (we) last saw the deceased alive on <u>09/16/1972</u> and that in <u>XX</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(X)</u> (We) (did) <u>(XXX)</u> view the body after death.							
23A. SIGNATURE <i>L. Buckler</i>				23B. DATE SIGNED 09 16 72			
23C. PHYSICIAN'S NAME (Type) L. BUCKLER, M.D.				23D. ADDRESS ST AGNES HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-19-1972		24C. NAME OF CEMETERY OR CREMATORY Ivy Hill Cemetery		24D. LOCATION (City, town, or county) (State) Laurel, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 21 1972		25B. NAME OF REGISTRAR <i>Adrian W. Hinton</i>		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		ADDRESS	

LEWIS, ELVA PAULINE

MARYLAND

BALTIMORE

ST AGNES HOSPITAL

1ST & 2ND BATTALION STREET - BALTIMORE

1911-1912

FRANK C. CANNON

MARYLAND

HOUSEWIFE

LILLIAN CANNON

RICHARD MICHAEL

ST AGNES HOSPITAL BALTIMORE  
212 12 1912

ST AGNES HOSPITAL

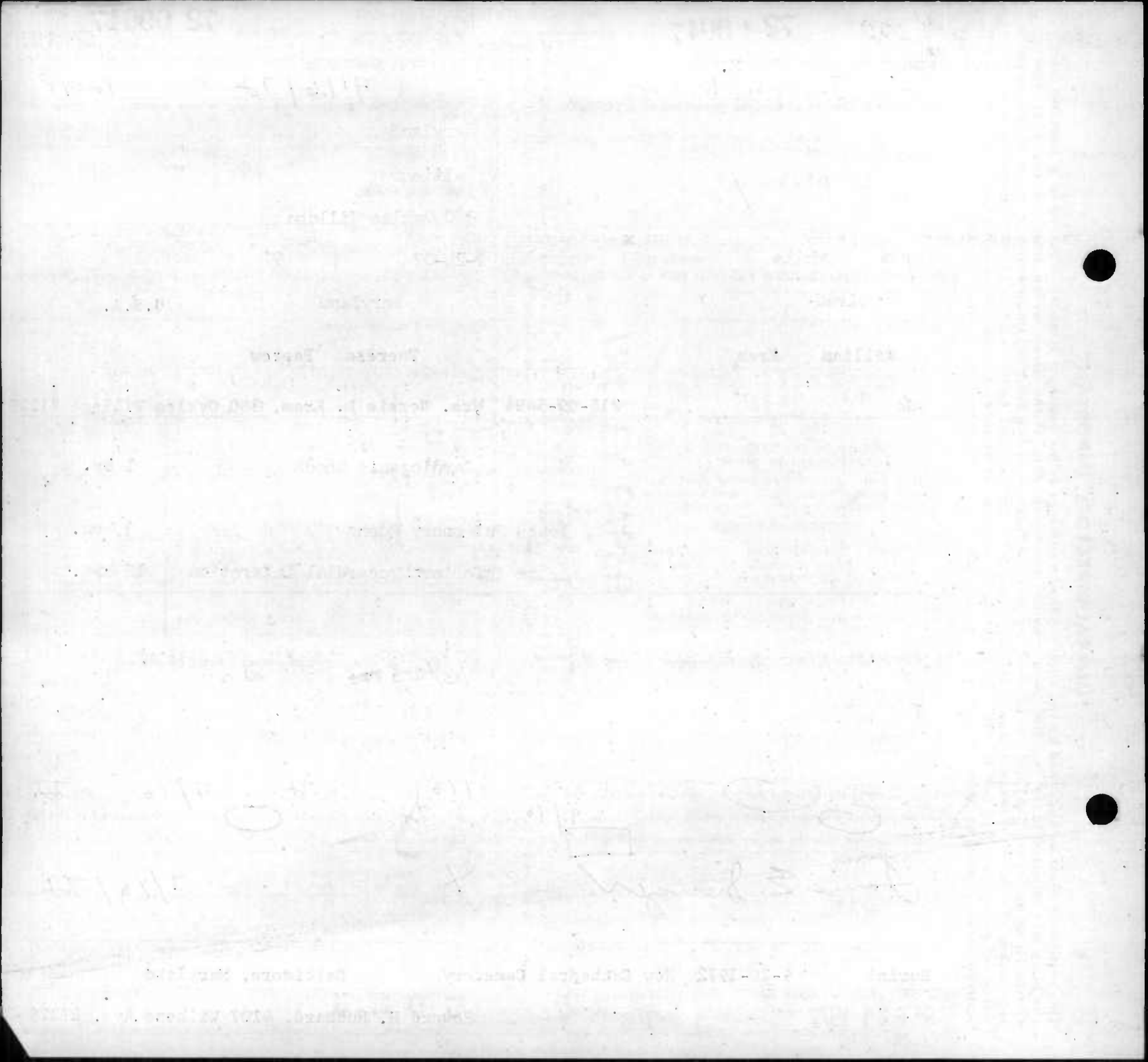
L. DUNCAN, M.D.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09047	
K-650 72 09047				STATE OF MARYLAND - DEATH	
1. NAME OF DECEASED (Type or Print) <b>M. Joseph Kram</b>		2. DATE AND HOUR OF DEATH <b>9/16/72 1201 P. M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>37 Mercy</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>BALTO</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>380 Oaklee Village</b>			
5. SEX <b>male</b>	6. RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-24-07</b>	9. AGE (In years last birthday) <b>65</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Kram</b>			14. MOTHER'S MAIDEN NAME <b>Theresa Paetow</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-09-5494</b>		17. INFORMANT ADDRESS <b>Mrs. Norsie L. Kram, 380 Oaklee Village 21229</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardiogenic Shock</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Acute Pulmonary Edema</b> <b>Acute Inferior Myocardial Infarction</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>3 hrs.</b> <b>12 hrs.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>9/16/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/16</b> 19 <b>72</b> to <b>9/16</b> 19 <b>72</b> , that (I) (we) lost saw the deceased alive on <b>9/16</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Louis E. Shaffer</b>				23B. DATE SIGNED <b>9/16/72</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-20-1972</b>		24C. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 21 1972</b>			
25B. NAME OF REGISTRAR <b>Sidney W. Horton</b>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard</b>			





FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">72 C9048</span>	
C-416 72 09048				STATE OF MARYLAND - DEPT	
BIRTH NO.				DEATH NO.	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
CLIFFORD, NAOMI THELMA			SEPTEMBER 17, 1972 3:38 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  40 ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229			A. STATE MARYLAND B. COUNTY 21230		
5. SEX FEMALE			6. RACE CAUCASIAN		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
HOUSEWIFE					MARYLAND
13. FATHER'S NAME HENRY KEIM			14. MOTHER'S MAIDEN NAME ALICE JONES		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 212-28-1883		17. INFORMANT BALTO MD 21229 ST AGNES' RECORDS CATON & WILKENS AVES
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 410.9 + 250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH Respiratory arrest		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute pulmonary edema		
			(B) DUE TO, OR AS A CONSEQUENCE OF: Myocardial infarction		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			Diabetes Mellitus		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (M) (this hospital) attended the deceased from SEPTEMBER 17 19 72 to SEPTEMBER 17 19 72, that (X) (we) last saw the deceased alive on SEPTEMBER 17 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.					
23A. SIGNATURE Vincent H. Wang M.D.			23B. DATE SIGNED 09/17/72		23C. PHYSICIAN'S NAME (Type) VINCENT H. WANG, M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 9-20-1972		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery
25A. DATE REC'D BY HEALTH DEPT. SEP 21 1972			25B. NAME OF REGISTRAR Adony H. Hubbard		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229

ANALYT. INVERSE, 01024122.

350HITZAO

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1903-1934 H.C. WHEAT

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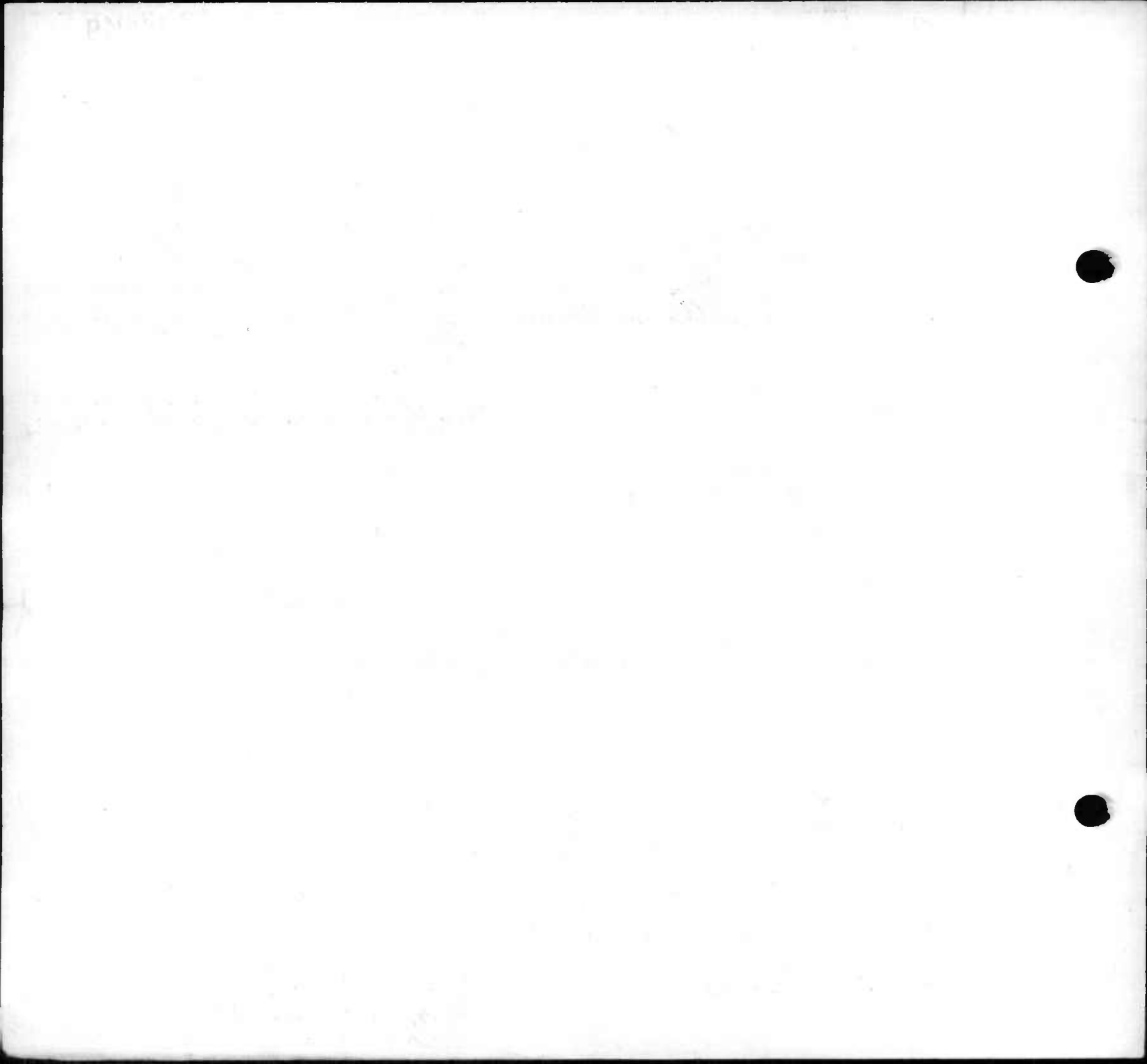
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# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				72 09049		72 09049	
CERTIFICATE OF DEATH				STATE OF MARYLAND-DEHE		REG. NO.	
BIRTH NO. <span style="float: right;">R-200</span>				2. DATE AND HOUR OF DEATH 9/20/1972 8 45 PM 1 8 45 P.M.			
1. NAME OF DECEASED (Type or Print) <u>Rose - Mrs Sue M.</u>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>CHURCH HOME &amp; HOSPITAL</u> <u>35</u>			
4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>301</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <u>Church Home &amp; Hosp</u> <u>100 N. Broadway Baltimore MD 21231</u>	
5. SEX <u>F</u>	6. RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-16-1876</u>	9. AGE (In years last birthday) <u>95</u>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>West Point, Va.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Jeffries</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Diggs</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-10-1354</u>		17. INFORMANT <u>Mrs. Richard D. Roop</u>		ADDRESS <u>603 Amherst Rd 21210</u>	
18. <u>497.21</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>0</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiopulmonary arrest</u> <u>Hyperpyrexia</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>5/23/1966</u> to <u>9/20/1972</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>9/20/1972</u> and that in <input checked="" type="checkbox"/> (my) <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>M. Yousuf Siddiqui MD.</u>				23B. DATE SIGNED <u>9/20/1972</u>		23C. PHYSICIAN'S NAME (Type) <u>M. YOUSUF SIDDIQUI MD.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>9/23/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>	
24D. LOCATION <u>Baltimore County, Md.</u>				25A. DATE REC'D BY HEALTH DEPT. <u>SEP 21 1972</u>		25B. NAME OF REGISTRAR <u>Arlene Robinson</u>	
25C. FUNERAL DIRECTOR <u>Funeral Services</u>				25D. ADDRESS <u>4905 York Rd. Balt. Md.</u>			



1

STATE OF MARYLAND DEPT. OF HEALTH  
BALTIMORE CITY HEALTH DEPARTMENT

72 09050  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 5-530 REG. NO. 72 09050

1. NAME OF DECEASED (Type or Print) <b>JOHNNIE LEE SMITH</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2401 Annor Ct.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour M. <b>9 19 1972 9:45p</b>	
6. SEX <b>male</b>		7. RACE <b>negro</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto. Md.</b>	
9. DATE OF BIRTH <b>OCT 17, 1940</b>		10. AGE (In years, months, days, hours, minutes) <b>31</b>	
11. BIRTHPLACE (State or foreign country) <b>VA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JAMES SMITH</b>		14. MOTHER'S MAIDEN NAME <b>MARY VALENTINE</b>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		16. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		18. SOCIAL SECURITY NO. <b>231565712</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>EYEBALL</b>		20. CAUSE OF DEATH <b>Gunshot wound of head</b>	
21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		22. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		24. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
25A. DATE OF OPERATION <b>2</b>		26. CONDITION FOR WHICH OPERATION WAS PERFORMED	
27. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>home</b>	
29. TIME (Month) (Day) (Year) (Hour) (Approx.) <b>9-19-72 9:15 p m.</b>		30. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
31. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>2401 Annor Ct.</b>		32. HOW DID INJURY OCCUR? <b>Shot during domestic argument.</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Ronald N. Kornblum</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>9/25/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>ARBUTUS MEM. PARK</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE COUNTY MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 22 1972</b>		25B. NAME OF REGISTRAR <b>DONALD E. GLOVER</b>	
25C. FUNERAL DIRECTOR <b>DONALD E. GLOVER</b>		25D. ADDRESS <b>712 E NORTH AVE</b>	

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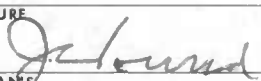
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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <b>72 09051</b>
<b>BIRTH NO.</b> <div style="font-size: 2em; font-weight: bold; margin-left: 10px;">H-536</div>		<b>STATE OF MARYLAND - DEPT.</b>		
<b>1. NAME OF DECEASED</b> (Type or Print) <b>Catherine E. Hinternesch</b>		<b>2. DATE AND HOUR OF DEATH</b> <b>9/18/1972</b>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>90 Caton Manor Home</b>		<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2008</b> <b>C. CITY OR TOWN</b> <b>Baltimore</b> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <b>3511 Old Frederick Road</b>		
<b>5. SEX</b> <b>Female</b>	<b>6. RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>6/9/1898</b>	<b>9. AGE</b> (In years last birthday) <b>74</b>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Cook</b>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>Restaurant</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>13. FATHER'S NAME</b> <b>Michael J. Duffy</b>		
<b>14. MOTHER'S MAIDEN NAME</b> <b>Catherine Carr</b>		<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
<b>16. SOCIAL SECURITY NO.</b> <b>218-01-5172</b>		<b>17. INFORMANT</b> <b>ADDRESS</b> <b>Mrs Margaret E. Larsen Benzinger Rd. 3557</b>		
<b>18. CAUSE OF DEATH</b> <b>410.9 I</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Acute MI</b> <b>instantly</b> <b>ANTECEDENT CAUSES</b> <b>A.S.C.V.D.</b> <b>year</b> <b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>				
<b>MEDICAL CERTIFICATION</b> <b>19A. DATE OF OPERATION</b> <b>0</b>				
<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>				
<b>20A. AUTOPSY? (Yes or No)</b>				
<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>				
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		
<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)		<b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)		
<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>		
<b>22. I certify that (I) (this hospital) attended the deceased from 1960 to 9/18 1972, that (I) (we) last saw the deceased alive on 9/18 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>				
<b>23A. SIGNATURE</b> 				<b>23B. DATE SIGNED</b> <b>9/20/72</b>
<b>23C. PHYSICIAN'S NAME</b> (Type) <b>J. Edward M.D.</b>				<b>23D. ADDRESS</b> <b>DEGREE</b>
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>24B. DATE</b> <b>9/21/1972</b>		
<b>24C. NAME OF CEMETERY OR CREMATORY</b> <b>St. Paul's Lutheran</b>		<b>24D. LOCATION</b> (City, town, or county) (State) <b>Violetville, Maryland</b>		
<b>25A. DATE-REC'D BY HEALTH DEPT.</b> <b>SEP 22 1972</b>		<b>25B. NAME OF REGISTRAR</b> <b>Sidney Johnston</b>		
<b>25C. FUNERAL DIRECTOR</b> <b>G. Truman Schwab</b>		<b>ADDRESS</b> <b>3512 Frederick Ave.</b>		

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## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-530 72 09052		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09052	
BIRTH NO.		JAMES		STATE OF MARYLAND - DUMFRIES	
1. NAME OF DECEASED (Type or Print) <i>Bennett, Hail</i>		2. DATE AND HOUR OF DEATH <i>9/17/72</i>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>Baltimore City Hospitals</i>	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Delaware</i> B. COUNTY <i>V07</i>		C. CITY OR TOWN <i>Frankford</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <i>Male</i>		6. RACE <i>Caucasian</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>11/23/13</i>		9. AGE (In years last birthday) <i>58</i>		10. If Under 1 Yr. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>POULTRYMAN</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>CHICKENS</i>		11. BIRTHPLACE (State or foreign country) <i>Delaware</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>ASA BENNETT</i>		14. MOTHER'S MAIDEN NAME <i>Ivy MILLER</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>WORLD #2 US Coast Guard</i>		16. SOCIAL SECURITY NO. <i>221-22-1905</i>		17. INFORMANT BCH Records: <i>4940 Eastern Ave. Baltimore, Md. 21224</i>	
18. <i>205.0</i>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>CVA</i>			
		(B) <i>Acute Myelogenous Leukemia</i> DUE TO, OR AS A CONSEQUENCE OF:			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>YES</i>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (this hospital) attended the deceased from <i>9/15</i> 19 <i>72</i> to <i>9/17</i> 19 <i>72</i> that (we) lost saw the deceased alive on <i>9/17</i> 19 <i>72</i> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) <i>did</i> (did not) view the body after death.			
23A. SIGNATURE <i>Roland K. Einhorn, M.D.</i>		23B. DATE SIGNED <i>9/17/72</i>		23C. PHYSICIAN'S NAME (Type) <i>Roland Einhorn M.D.</i>	
23D. ADDRESS <i>Baltimore City Hospitals</i>		23E. ADDRESS <i>4940 Eastern Ave. Baltimore, Md. 21224</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>9/21/72</i>		24C. NAME OF CEMETERY or CREMATORY <i>RED MEN</i>	
24D. LOCATION (City, town, or county) (State) <i>SELBYVILLE SUSSEX, DEL.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>SEP 22 1972</i>		25B. NAME OF REGISTRAR <i>Sidney Whitson</i>	
25C. FUNERAL DIRECTOR <i>Peter W. Whaley</i>		25D. ADDRESS <i>Selbyville, Del.</i>			

WILKES 117 Great Court 251-11-1802  
42A BENNETT  
BETTERMAN CHICKENS

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>K-140</b>				BALTIMORE CITY HEALTH DEPARTMENT		72 09053		CERTIFICATE OF DEATH		REG. NO. <b>72 09053</b>	
1. NAME OF DECEASED (Type or Print) <b>Birdie Lee Kolbe</b>				2. DATE AND TIME OF DEATH <b>9/19/72 4:05 AM</b>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>33 The Johns Hopkins Hospital</b>			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>BALTIMORE</b> B. COUNTY <b>MD.</b>				5. CITY OR TOWN <b>Baltimore 21221</b>				6. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
7. STREET AND NUMBER <b>501 Armstrong Lane</b>				8. DATE OF BIRTH <b>03/14/11</b>				9. AGE (In years last birthday) <b>61</b>			
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Aide</b>				11. BIRTHPLACE (State or foreign country) <b>Texas</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>William Stockton</b>				14. MOTHER'S MAIDEN NAME <b>Mattie Louise Seagraves</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>463 14 6363</b>				17. INFORMANT <b>Franklin Kolbe 8706 Fontana Lane 21237</b>				18. <b>174X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Supra</b>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Metastatic breast cancer</b>				20. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Supra</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Metastatic breast cancer</b> (C) <b>none</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>36 hours</b> <b>2 years</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION <b>9/1/72</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>breast c.s.</b>				20A. AUTOPSY (Yes or No) <b>NO</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>NO</b>				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>9/24/72</b> 19 to <b>9/19/72</b> 19, that (I) (we) last saw the deceased alive on <b>9/19/72</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (do) view the body after death.											
23A. SIGNATURE <b>E.H. Withers M.D.</b>				23B. DATE SIGNED <b>9/19/72</b>				23C. PHYSICIAN'S NAME (Type) <b>E.H. WITHERS M.D.</b>			
23D. ADDRESS <b>601 N. Broad St.</b>				24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>9/22/72</b>			
24C. NAME OF CEMETERY or CREMATORY <b>Belair Memorial Gardens</b>				24D. LOCATION (City, town, or county) (State) <b>Belair, Maryland</b>				25A. DATE REC'D BY HEALTH DEPT. <b>SEP 22 1972</b>			
25B. NAME OF REGISTRAR <b>Franklin Kolbe</b>				25C. FUNERAL DIRECTOR <b>Brazdzinski Funeral Home</b>				25D. ADDRESS <b>1407 Eastern Ave.</b>			

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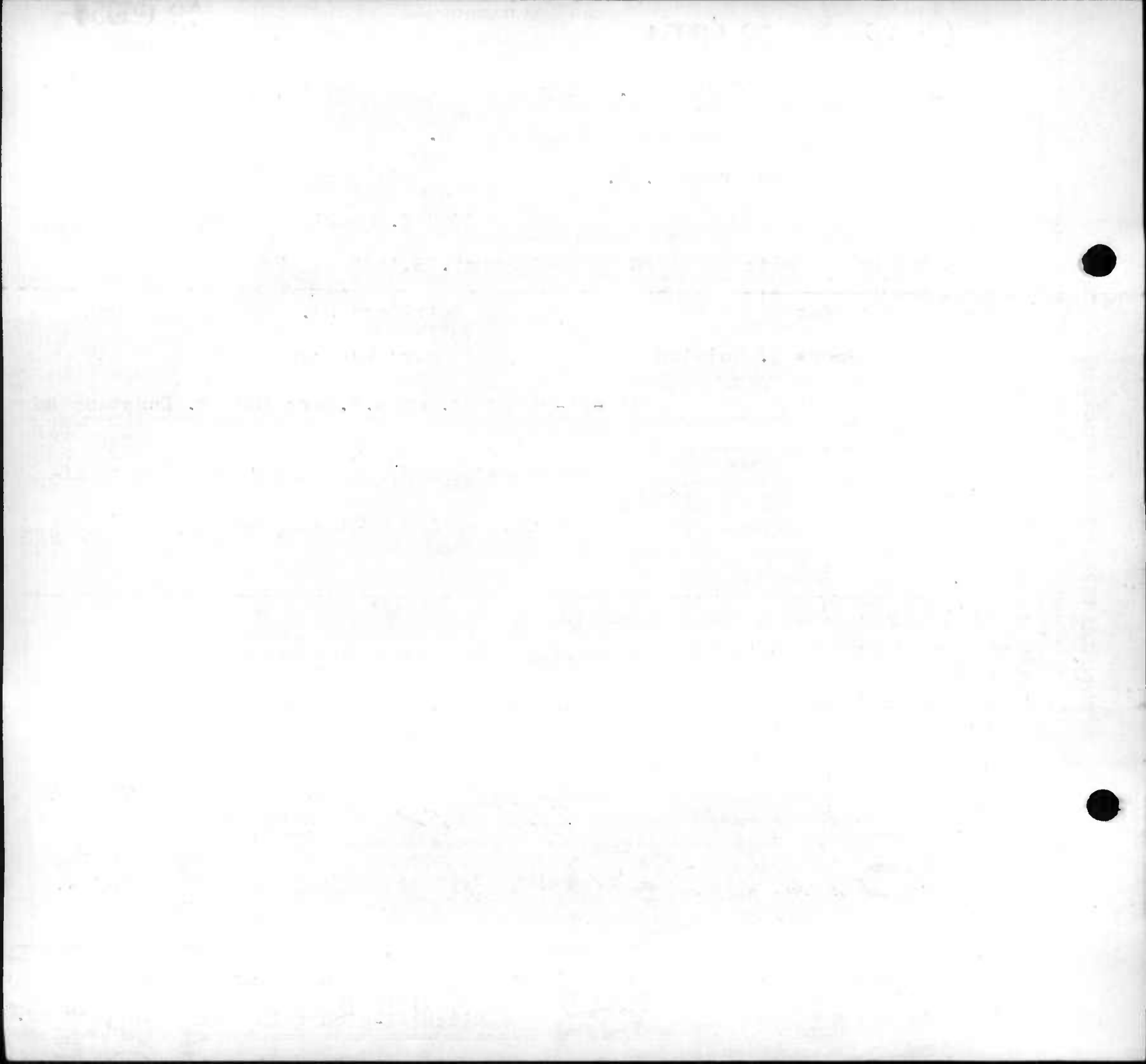
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FUNERAL DIRECTOR: IMPORTANT

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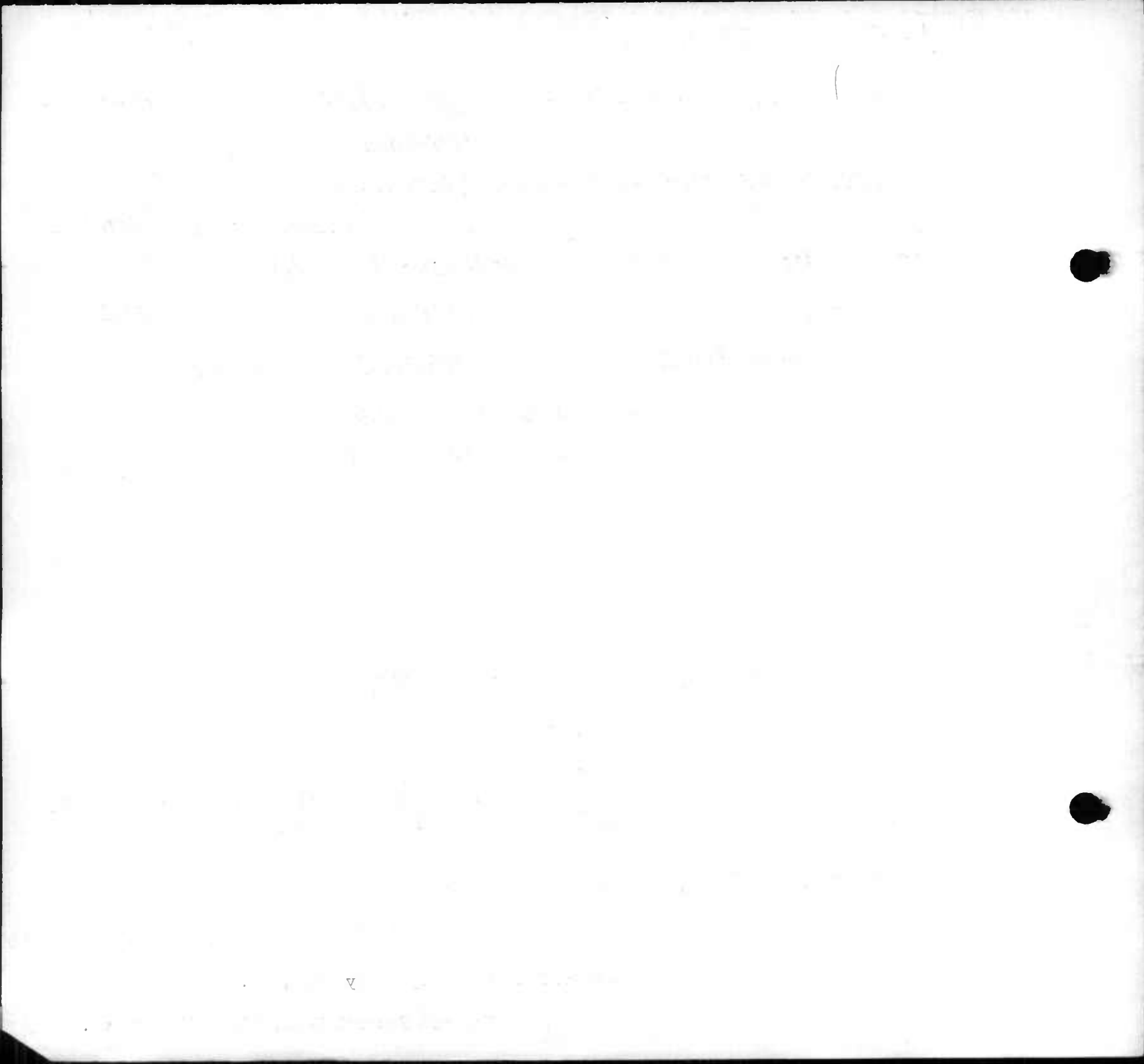
BALTIMORE CITY HEALTH DEPARTMENT		72 09054		72 09054	
C-600		72 09054		72 09054	
BIRTH NO.		72 09054		72 09054	
1. NAME OF DECEASED (Type or Print)		Mildred K. Carr		2. DATE AND HOUR OF DEATH Sept 19, 1972 1:35 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY		1201	
FULL NAME OF HOSPITAL OR INSTITUTION 90		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Long Green N. H.		C. CITY OR TOWN Baltimore	
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 3900 N. Charles Street		F. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Oct. 23, 1898		9. AGE (In years last birthday) 73		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME James J. Quinlan		14. MOTHER'S MAIDEN NAME Mary Kennedy	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212001-36820		17. INFORMANT Dr. Chas. E. Carr 108 St. Dunstons Rd	
18. 433.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral thrombosis (B) DUE TO, OR AS A CONSEQUENCE OF: Cerebral arteriosclerosis (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 5 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 9/18/72 to 9/19/72, that (I) (we) last saw the deceased alive on 9/18/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Charles J. Blazek M.D.	
23B. DATE SIGNED 9/20/72		23C. PHYSICIAN'S NAME (Type) CHARLES J. BLAZEK		23D. ADDRESS 1116 St Paul St	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/21/72		24C. NAME OF CEMETERY or CREMATORY New Cathedral	
24D. LOCATION (City, town, or county) (State) Baltimore Maryland		25A. DATE REC'D BY HEALTH DEPT. SEP 22 1972		25B. NAME OF REGISTRAR Audrey Wiedefeld	
25C. FUNERAL DIRECTOR Mitchell Wiedefeld Home		25D. ADDRESS 6500 York Rd.		25E. ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

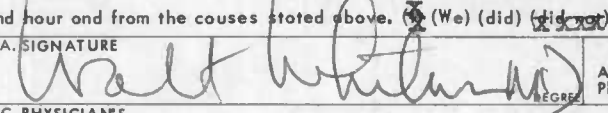
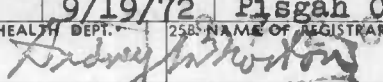
1-652		72 09055		BALTIMORE CITY HEALTH DEPARTMENT		72 09055	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) MITCHELL LAWRENCE				2. DATE AND HOUR OF DEATH 9/19/72 8:20 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTO			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY OF MARYLAND Hospital 38				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 4-26-11	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE KNOWN		10B. KIND OF BUSINESS OR INDUSTRY UNKNOWN		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ISSAC LAWRENCE				14. MOTHER'S MAIDEN NAME NETTIE WIGGINS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-05-6940		17. INFORMANT CHART.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CARCINOMA OF RIGHT EAR. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 YRS	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 8/25/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED GASTROSTOMY - INABILITY TO SWALLOW.		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NO		21C. WHERE DID INJURY OCCUR? NO		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) NO		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? NO			
22. I certify that (I) (this hospital) attended the deceased from AUGUST 3 19 72 to SEPT 19 19 72 that (II) (we) last saw the deceased alive on SEPT 19 19 72 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE James A. Steward MD				23B. DATE SIGNED 9/19/72		23C. ADDRESS UNIVERSITY OF MARYLAND Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 22 1972		25B. NAME OF REGISTRAR Adrian W. Horton		25C. FUNERAL DIRECTOR Hubbard Funeral Home, 4107 Wilkens Ave.		ADDRESS	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 09056</b>
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <b>ZEIGLER, David Madsion</b>		<b>2. DATE AND HOUR OF DEATH</b> <b>September 15, 1972</b> <b>3:00 P</b> M.		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <b>Veterans Administration Hospital</b> <b>3900 Loch Raven Blvd.</b> <b>Baltimore, Maryland 21218</b>		<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>203</b> <b>C. CITY OR TOWN</b> <b>Baltimore</b> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <b>717 S. Bond Street</b> <b>21231</b>		
<b>5. SEX</b> <b>Male</b>	<b>6. RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>8/25/88</b>	<b>9. AGE</b> (In years last birthday) <b>84</b> <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired pipefitter Helper</b>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired pipefitter Helper</b>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>Plumbing</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Pennsylvania</b>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>13. FATHER'S NAME</b> <b>George Ziegler</b>		
<b>14. MOTHER'S MAIDEN NAME</b> <b>Rose Miller</b>		<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b> <b>2/13/13 to 7/23/19</b>		
<b>16. SOCIAL SECURITY NO.</b> <b>203-10-06-66</b>		<b>17. INFORMANT</b> <b>Records</b> <b>ADDRESS</b> <b>VAH, 3900 Loch Raven Blvd., Balto., Md.</b>		
<b>18. CAUSE OF DEATH</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> <b>Reticulum Cell Sarcoma</b> <b>(A) IMMEDIATE CAUSE</b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>5 years</b> <b>ANTECEDENT CAUSES</b> <b>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b>				<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <b>5 years</b>
<b>II</b>				
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b>				
<b>19A. DATE OF OPERATION</b> <b>0</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <b>No</b>		<b>20A. AUTOPSY? (Yes or No)</b> <b>No</b>
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location) <b>No</b>		<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) <b>(APPROX.)</b>
<b>21E. INJURY OCCURRED</b> <b>While At Work</b> <input type="checkbox"/> <b>Not While At Work</b> <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>		
<b>22. I certify that (he) (this hospital) attended the deceased from September 11, 1972 to September 15, 1972, that (he) (we) last saw the deceased alive on September 15, 1972 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.</b>				
<b>23A. SIGNATURE</b> 				<b>23B. DATE SIGNED</b> <b>9/16/72</b>
<b>23C. PHYSICIAN'S NAME</b> (Type) <b>Walt H. Whitman M.D.</b>		<b>23D. ADDRESS</b> <b>3900 Loch Raven Blvd., Balto., Md. 21218</b>		
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>24B. DATE</b> <b>9/19/72</b>		<b>24C. NAME OF CEMETERY OR CREMATORY</b> <b>Pisgah Cemetery</b>
<b>24D. LOCATION</b> (City, town, or county) (State) <b>Perry Co., Pennsylvania</b>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>SEP 22 1972</b>		
<b>25B. NAME OF REGISTRAR</b> 		<b>25C. FUNERAL DIRECTOR</b> <b>Wm. E. Johnson 8521 Loch Raven Bly</b>		

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09057	
72 09057				STATE OF MARYLAND - BALTO	
BIRTH NO. 7-430		1. NAME OF DECEASED (Type or Print) FLOYD, VERA B.		2. DATE AND HOUR OF DEATH SEPTEMBER 20, 1972 12:55A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL 40		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTO 5300		C. CITY OR TOWN BALTIMORE	
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 1215 ST AGNES LANE		21229	
5. SEX FEMALE	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-05-87	9. AGE (In years last birthday) 84	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NURSE - RN
10B. KIND OF BUSINESS OR INDUSTRY NURSING		11. BIRTHPLACE (State or foreign country) VERMONT		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HARRY FLOYD		14. MOTHER'S MAIDEN NAME (STEVENS) NELLIE		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. 143261949		17. INFORMANT RECORD'S BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVE		ADDRESS	
18. 448X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 0		CAUSE OF DEATH (A) IMMEDIATE CAUSE C. V. A. DUE TO, OR AS A CONSEQUENCE OF: (B) Hereditary Telangiectasia DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from SEPTEMBER 11, 19 72 to SEPTEMBER 20, 19 72, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on SEPTEMBER 20, 19 72 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.					
23A. SIGNATURE K. Esna M.D.		23B. DATE SIGNED 09-20-72		23C. PHYSICIAN'S NAME (Type) KHOSROW ESNA, M.D.	
23D. ADDRESS BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVE		23E. FUNDAL DIRECTOR Wm. E. Johnson 8521 Loch Raven Bly		23F. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/22/72		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cem.	
24D. LOCATION Balto. Co., Md.		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
24G. SEP 22 1972		24H. 2000		24I. 500	

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SEPTEMBER 10, 1957

ST JOHN'S HOSPITAL

MILWAUKEE

1212 ST ASHES LANE

12-05-57

VERMONT

(STEWART) KELLY

ST JOHN'S HOSPITAL

NO

SEPTEMBER 11, 1957

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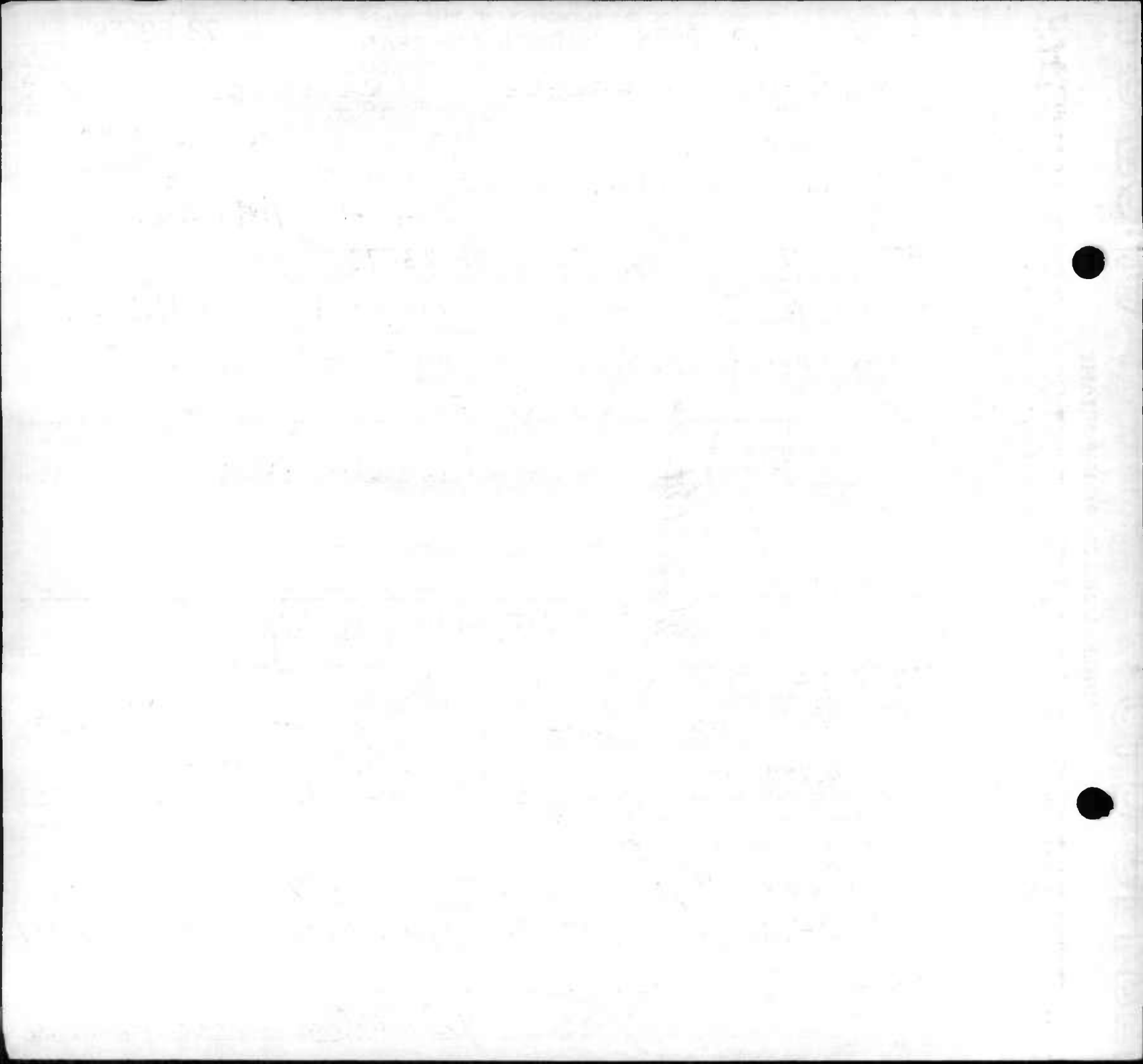
SEPTEMBER 20, 1957

Released on approval of medical examiner - A. K. ...

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-620		72 09058		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09058	
BIRTH NO.				STATE OF MARYLAND - DUMFRIES			
1. NAME OF DECEASED (Type or Print) SARAH (SADIE) E. FARACE				2. DATE AND HOUR OF DEATH 9-18-72 04:20 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY 2641			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Union Memorial Hospital 44				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 5524 Plainfield Ave.			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 06-28-93	9. AGE (In years last birthday) 79	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Unknown Andrew Ryan				14. MOTHER'S MAIDEN NAME McCourt, Margaret			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. D 212-03-9464		17. INFORMANT SON. The same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E 887X1 CAUSE OF DEATH BILATERAL PNEUMONIA 2 days APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, given rise to the above cause (A) stating rise to the above cause (A) stating UNDERLYING CONDITION lost.				Jewet mailing @ hip			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 109-12-72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fracture @ hip		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) X		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 5524 Plainfield Ave Balto		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) Sept-9, 1972	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Collapsed 4th Floor					
22. I certify that (I) (this hospital) attended the deceased from 09-09-72 to 09-18-1972 and that (I) (we) lost saw the deceased alive on 09-18-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Cesar A. Alegré				23B. DATE SIGNED 09-18-72		23C. PHYSICIAN'S NAME (Type) CESAR A. ALEGRE MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-22-72		24C. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL		24D. LOCATION (City, town, or county) (State) Balto., Md	
25A. DATE REC'D BY HEALTH DEPT. SEP 22 1972		25B. NAME OF REGISTRAR Sidney H. Horton		25C. FUNERAL DIRECTOR J. Walter Corblin		25D. ADDRESS 5444 BELAIR RD	





STATE OF MARYLAND - DISTRICT		BALTIMORE CITY HEALTH DEPARTMENT	
I-634		72 09059	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 72 09059	
BIRTH NO. A-634			
1. NAME OF DECEASED (Type or Print) Dorothy P. ARDELLA		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 9 Day 16 Year 72 Hour 3:00 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hospital		3. DATE PRONOUNCED DEAD Month 9 Day 16 Year 72 Hour 3:00 A.M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH March 30, 1900		10. AGE (in years last birthday) 72	
11. BIRTHPLACE (State or foreign country) BALTO., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John P. ARDELL		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CLERICAL WORKER	
15. MOTHER'S MAIDEN NAME MARIE KAPLAN		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	
17. SOCIAL SECURITY NO. 212-12-1563		18. INFORMANT ADDRESS Mrs. MARGARET CRAYTON 4509 WHITE AVE.	
19. 412.4		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Arteriosclerotic cardiovascular disease	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE William P. Mulloy, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) William P. Mulloy, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-20-1972	
24C. NAME OF CEMETERY OR CREMATORY MEADOW RIDGE MEM. PK.		24D. LOCATION (City, town, or county) (State) HOWARD CO. MD	
25A. DATE REC'D BY HEALTH DEPT. SEP 22 1972		25B. NAME OF REGISTRAR Sidney H. HARTMAN	
25C. FUNERAL DIRECTOR J. Walter Conklin		ADDRESS 5444 BELAIR RD.	

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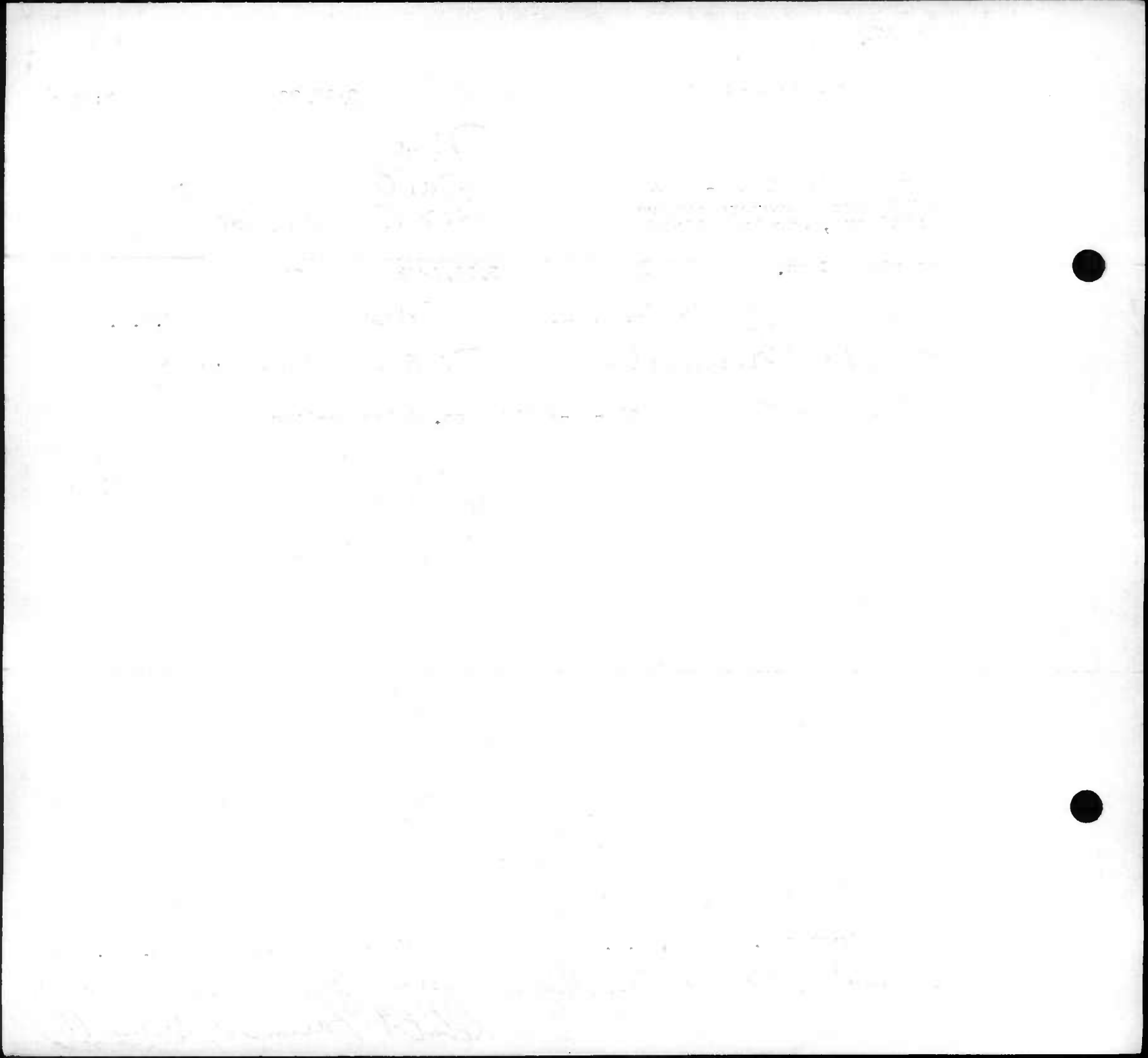
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09060	
72 09060 CERTIFICATE OF DEATH				STATE OF MARYLAND - PHILADELPHIA	
B-452 BIRTH NO.		1. NAME OF DECEASED (Type or Print) HELEN BLANCHARD		2. DATE AND HOUR OF DEATH 9/19/72 3:00 a.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore		C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION HOUSE IN THE PINES - BELVEDERE 2525 West Belvedere Avenue Baltimore, Maryland 21215		E. STREET AND NUMBER 1507 Convent St			
5. SEX Female	6. RACE Caus.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/31/1893	9. AGE (In years last birthday) 79	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife @ home		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME Frank Bremmich		14. MOTHER'S MAIDEN NAME Mary Brooks		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-01-9857D		17. INFORMANT Mrs. Helen Mueller	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute M.I. a.s.v.d. (B) RO Hemiplegia DUE TO, OR AS A CONSEQUENCE OF: a.s.v.d. (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr. 10 yr. 10 yr.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 19 1972 to Sept 19 1972 that (I) (we) last saw the deceased alive on Sept 15 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lester N. Kolman, M.D.		23B. DATE SIGNED 9/24/72		23C. PHYSICIAN'S NAME (Type) Lester N. Kolman, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-21-72		24C. NAME OF CEMETERY OR CREMATORY Glen Haven Cem.	
24D. LOCATION Glen Burnie Md.		24E. ADDRESS 6821 Reisterstown Road Balto. Md. 21215		24F. ADDRESS (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. SEP 22 1972		25B. NAME OF REGISTRAR Sidney Johnson		25C. FUNERAL DIRECTOR Robert S. Baranov, Severn Pk.	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 09061

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>GEORGE HOLTON</b>				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> _____ M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Provident Hosp.</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>9 10 1972 10:17a</b> M.			
6. SEX <b>male</b>				7. RACE <b>negro</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>Mar 5, 1926</b>				10. AGE (In years lost birthday) <b>46</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Amber</b>		14. MOTHER'S MAIDEN NAME <b>Amber</b>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>				16. KIND OF BUSINESS OR INDUSTRY <b>None</b>			
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>				18. SOCIAL SECURITY NO. <b>None</b>		19. INFORMANT <b>Helena P. Holton</b>	
20. ADDRESS <b>Same</b>				21. CAUSE OF DEATH <b>Fatty metamorphosis of liver</b>			
22. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</b>				23. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:			
24. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				25. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
26. DATE OF OPERATION <b>2</b>				27. CONDITION FOR WHICH OPERATION WAS PERFORMED			
28. AUTOPSY? (Yes or No) <b>yes</b>				29. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
30. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				31. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
32. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>m.</b>				33. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
34. HOW DID INJURY OCCUR?				35. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
36. ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b>				37. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
38. DATE SIGNED <b>9-11-72</b>				39. 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
40. 24B. DATE <b>9-14-72</b>				41. 24C. NAME OF CEMETERY or CREMATORY <b>MT. Calvary Cem.</b>			
42. 24D. LOCATION (City, town, or county) (State) <b>Brooklyn Md.</b>				43. 25A. DATE REC'D BY HEALTH DEPT. <b>SEP 22 1972</b>			
44. 25B. NAME OF REGISTRAR <b>Adrian Hinton</b>				45. 25C. FUNERAL DIRECTOR <b>Ph 57 O. Wilson 1000 Buntly Ave.</b>			

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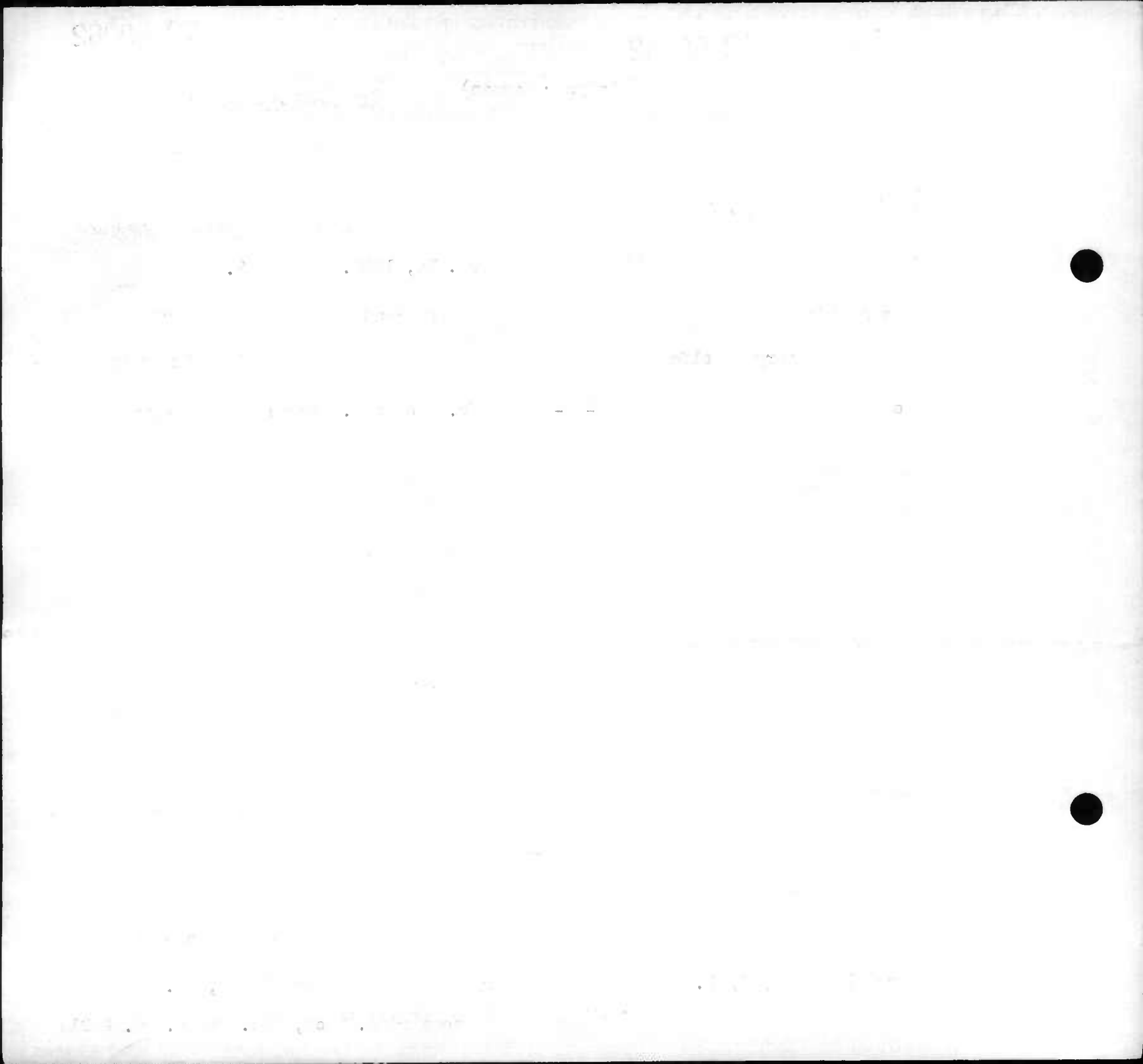
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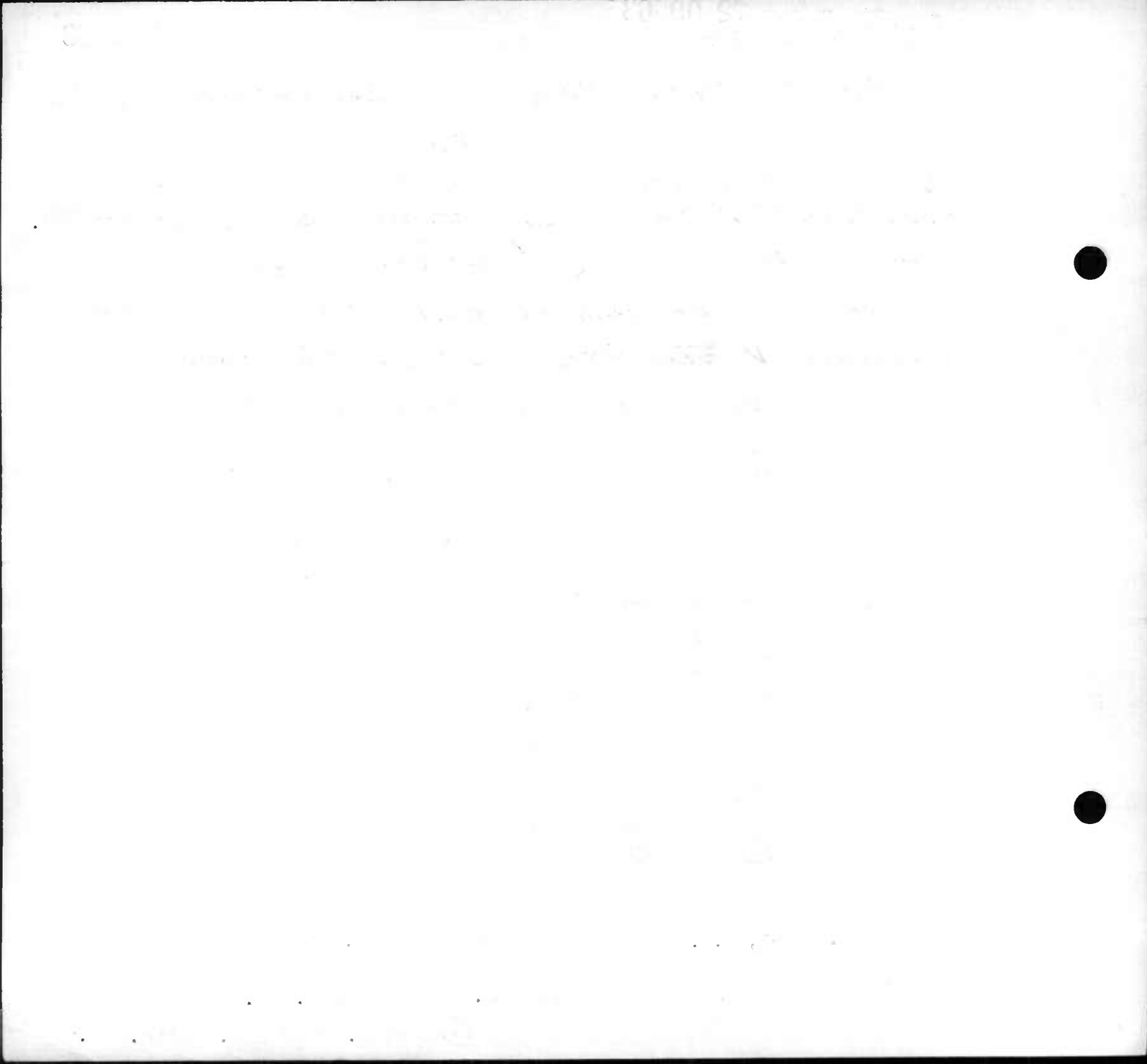
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09062		72 09062	
BIRTH NO.				REG. NO.		STATE OF MARYLAND-DEATH	
1. NAME OF DECEASED (Type or Print) <b>GLADYS BAUMAN (Gladys M Bauman)</b>				2. DATE AND HOUR OF DEATH <b>20 SEPT. 1972 6 35 AM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Union Memorial Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>md.</b> B. COUNTY <b>Northern District</b>			
				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>3606 NORTHERN PARKWAY</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 16, 1900.</b>		9. AGE (In years last birthday) <b>72.</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Henry Wolfe</b>				14. MOTHER'S MAIDEN NAME <b>Emily Zimmerman</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>213-74-9051</b>		17. INFORMANT <b>Mr. George L. Bauman</b>	
						ADDRESS <b>(Same)</b>	
1B. <b>553.8 I</b> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <b>Cerebrovascular Accident</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) <b>Thrombocytopenia</b> DUE TO, OR AS A CONSEQUENCE OF:  (C) <b>Splenic infarct hemorrhage</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>9/17/72</b> 19 <b>72</b> to <b>9/20/72</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>9/19</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>John J. Ruck</b>				23B. DATE SIGNED <b>20/9/72</b>			
23C. PHYSICIAN'S NAME (Type) <b>MB BCh.</b>				23D. ADDRESS <b>Union Memorial Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/23/72.</b>		24C. NAME of CEMETERY or CREMATORY <b>Parkwood Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 22 1972</b>		25B. NAME OF REGISTRAR <b>Adrian W. Horton</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc.</b>		ADDRESS <b>Balto. Md. 21214</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-460 72 09063		BALTIMORE CITY HEALTH DEPARTMENT		72 09063	
Edward Vinton Aler		CERTIFICATE OF DEATH		REG. NO.	
BIRTH NO.		STATE OF MARYLAND		DEPT	
1. NAME OF DECEASED (Type or Print) <b>EDWARD VINTON Aler</b>		2. DATE AND HOUR OF DEATH <b>Sept. 21, 1972 6 30 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>2748</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Keswick Home for Incapables 700 W. 40th Street 21211</b>		C. CITY OR TOWN <b>BAITO</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Male</b> 6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-5-1883</b> 9. AGE (In years last birthday) <b>88</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>B. &amp; O Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>BAITO, Md.</b>	
13. FATHER'S NAME <b>EMANUEL V. Aler</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth HARR</b>			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO NO</b>		16. SOCIAL SECURITY NO. <b>205-05-2861</b>		17. INFORMANT <b>Keswick Files</b> ADDRESS	
18. <b>412.4 I</b> CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1. This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cerebral Hemorrhage</b>		<b>18 hrs</b>	
2. ANTECEDENT CAUSES		(B) <b>Arteriosclerotic CVD</b> DUE TO, OR AS A CONSEQUENCE OF:		<b>many yrs</b>	
3. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>February 1970</b> to <b>21 Sept 1972</b> that (I) (we) last saw the deceased alive on <b>21 Sept 1972</b> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Harold P. Biehl</b>		23B. DATE SIGNED <b>21 Sept 72</b>		23C. PHYSICIAN'S NAME (Type) <b>Harold P. Biehl, M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>9/23/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cem.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 22 1972</b>		25B. NAME OF REGISTRAR <b>Sidney W. Winton</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Huck Inc. Balto. Md.</b>	





A 450

72 09064

STATE OF MARYLAND - DISTRICT  
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 09064

BIRTH NO.

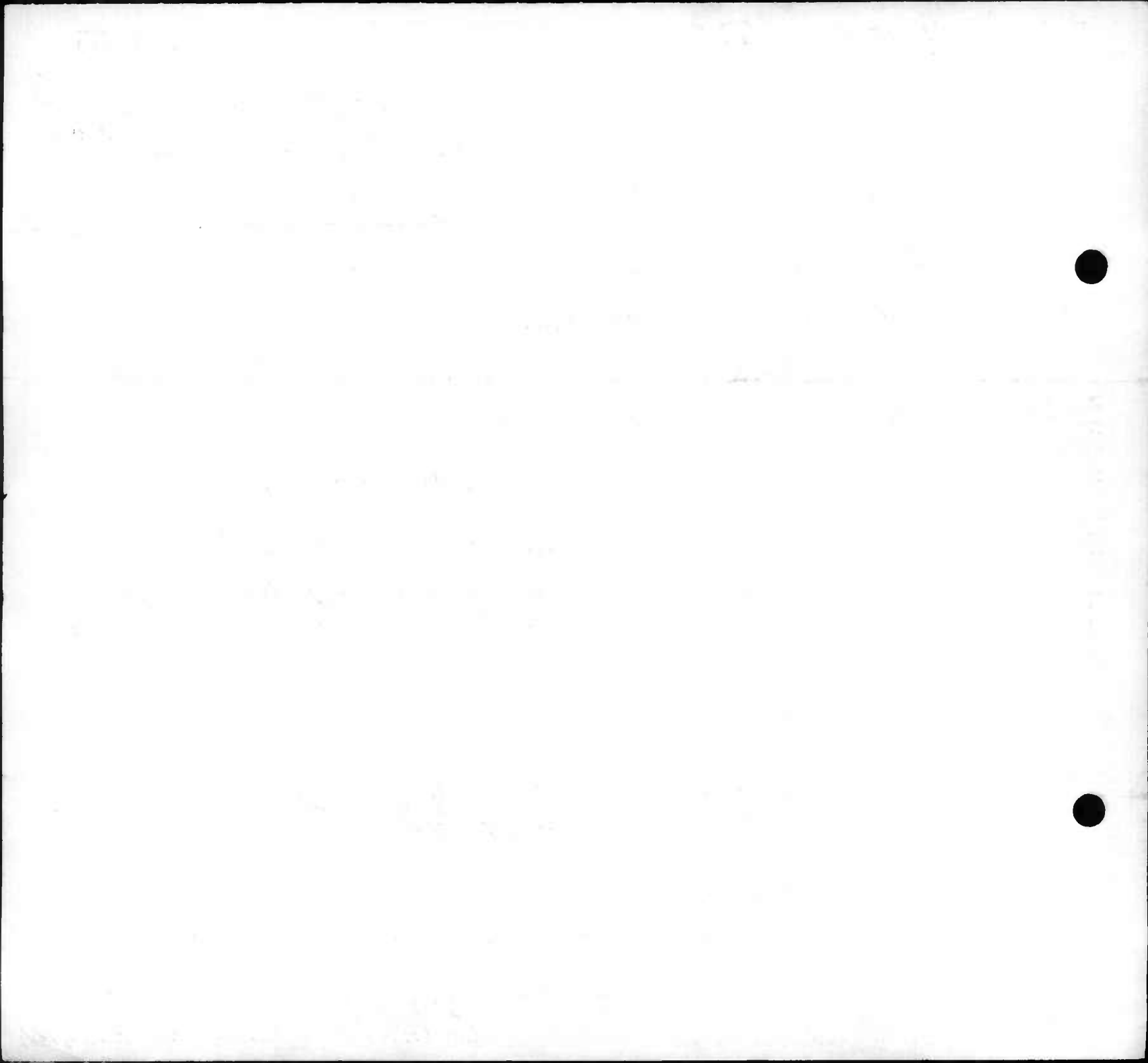
1. NAME OF DECEASED (Type or Print) Rosalie Allen		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 9 18 72 7:20 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospitals		3. DATE PRONOUNCED DEAD Month Day Year Hour 9 18 72 7:20 P. M.	
6. SEX Female		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2533	
9. DATE OF BIRTH May 12 1919		10. AGE (In years last birthday) 53	
11. BIRTHPLACE (State or foreign country) Hamilton, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin Lipscomb		14. MOTHER'S MAIDEN NAME Hazel Morris	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		18. SOCIAL SECURITY NO. 213 12 9205	
19. 571-91		19. CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Cirrhosis of liver DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) William P. Mulloy, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 9-19-72		24A. BURIAL CREMATION, REMOVAL (Specify) Burial	
24B. DATE 9/22/72		24C. NAME of CEMETERY or CREMATORY Arlington National	
24D. LOCATION (City, town, or county) (State) Arlington, Virginia		25A. DATE REC'D BY HEALTH DEPT. SEP 22 1972	
25B. NAME OF REGISTRAR George J. Gonce		25C. FUNERAL DIRECTOR ADDRESS 4001 Ritchie Hwy	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

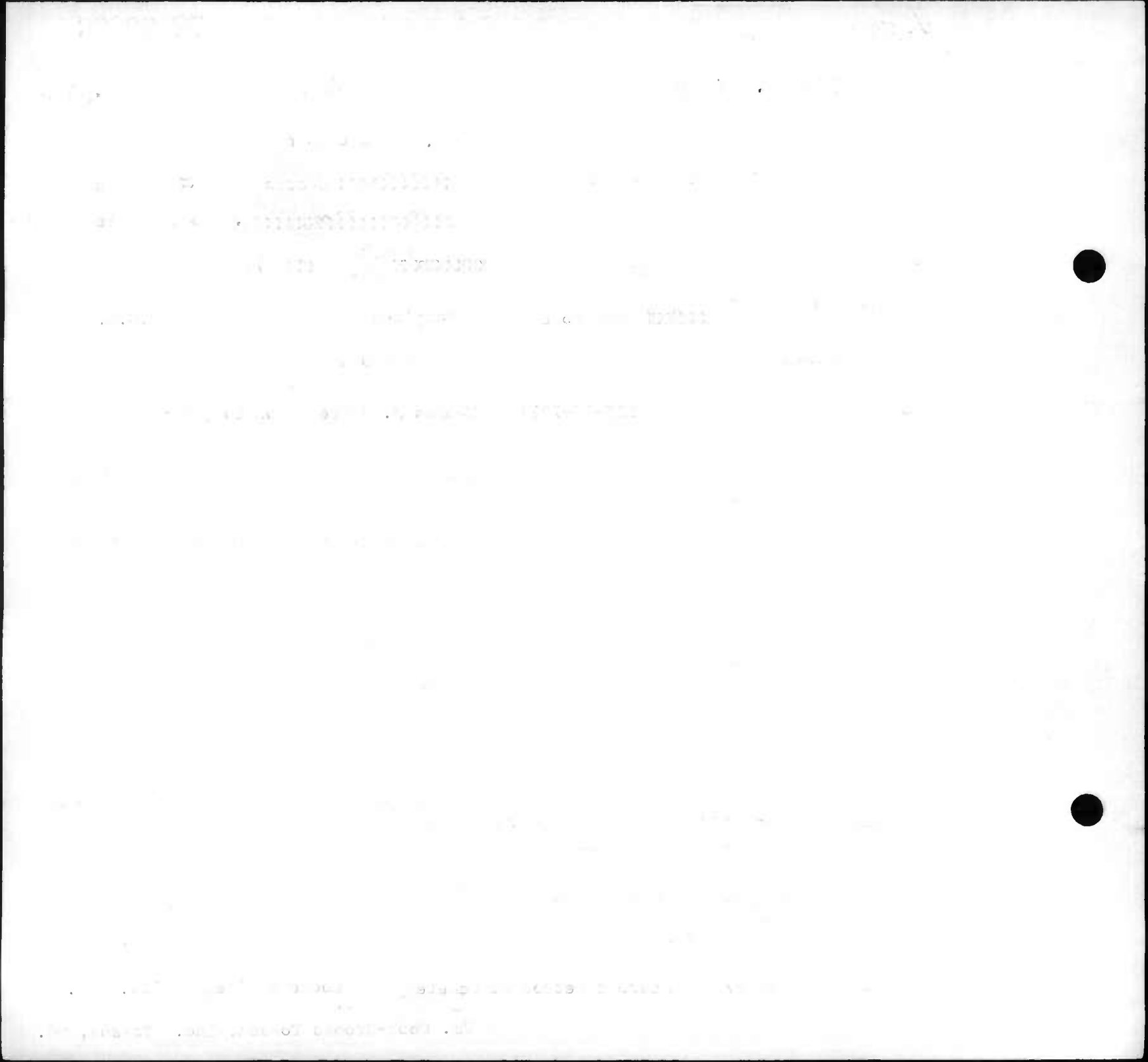
BIRTH NO. <span style="float: right;">A-450</span>		72 09065		BALTIMORE CITY HEALTH DEPARTMENT		72 09065	
CERTIFICATE OF DEATH				STATE OF MARYLAND-DEPT			
1. NAME OF DECEASED (Type or Print) <u>Allen-mabel</u>				2. DATE AND HOUR OF DEATH <u>9-17-72</u> <u>2:25</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, At institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Ashburton Nursing Home</u> <u>3520 Hilton Rd</u> <u>Baltimore</u>				A. STATE <u>MD</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3520 Hilton Rd</u> <u>3904</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 9, 1875</u>	9. AGE (In years last birthday) <u>97 yrs</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>David Hahn</u>				14. MOTHER'S MAIDEN NAME <u>Anna Pitchard</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-0982321</u>		17. INFORMANT ADDRESS			
18. <u>7/12-31</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>arteriosclerotic heart disease</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>yes</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>arteriosclerosis generalized</u>				(B) DUE TO, OR AS A CONSEQUENCE OF: <u>yes</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>chronic bronchitis</u> <u>osteoarthritis</u>				(C) <u>yes</u>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>July</u> 19 <u>65</u> to <u>9/17</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>9/17</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>9/19/72</u>			
23C. PHYSICIAN'S NAME (Type) <u>ALAN H MACHT MD</u>				23D. ADDRESS <u>2 E. Rad St Baltimore Md 21202</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>9-23-72</u>		24C. NAME of CEMETERY or CREMATORY <u>MORELAND MEM. PARK</u>		24D. LOCATION (City, town, or county) (State) <u>PARKVILLE, BALTO. MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 22 1972</u>		25B. NAME OF REGISTRAR <u>Sidney Johnston</u>		25C. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson, Inc. Towson, Md.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09066		72 09066	
BIRTH NO.				72 09066		REG. NO.	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH		STATE OF MARYLAND - DHMH	
Alice V. Hidey				9/20/72		2.30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		5. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				Md. Baltimore		5300	
90 Edgewood Nursing Home				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
Baltimore				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		NO <input type="checkbox"/>	
E. STREET AND NUMBER				6000 Bellona Ave		Post Office, Sparks	
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
F		W		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		12-25-1896	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		None Own Home		Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Unknown				Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
No				215-18-7243		Thomas J. Price Monkton, Maryland	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		2. yr	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		2 yr	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or compulsion which caused death.)				(B) Atherosclerotic cardiovascular dis		3 + yr	
ANTECEDENT CAUSES				DUE TO, OR AS A CONSEQUENCE OF:		(C)	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				no			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 11-17 1967 to 9-20 1972 that (I) (we) last saw the deceased alive on 9-15 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED		9-21-72	
Frederick J. Vollmer MD				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
F.J. VOLLMER MD				6100 YORK RD BALTO MD 21212			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		9-22-72		Jessops Methodist Cemetery		Cockeysville, Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
SEP 22 1972		F. J. Vollmer		Wm. Cook-Brooks Towson, Inc.		Towson, Md.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09067	
P-230 72 09067		CERTIFICATE OF DEATH	
BIRTH NO.		STATE OF MARYLAND - DISTRICT	
1. NAME OF DECEASED (Type or Print) PUKITA GEORGE		2. DATE AND HOUR OF DEATH September 18, 1972 11:35 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SOUTH BALTIMORE GENERAL HOSPITAL		A. STATE MARYLAND B. COUNTY Baltimore	
		C. CITY OR TOWN Edgemere D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER Box 254X North Point Road, Baltimore, Md. 21219	
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-25-1898
		9. AGE (in years last birthday) 73	10. UNDER 1 Yr. Months: Days: 11. UNDER 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bethlehem Steel Co.		10B. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME Gregory Pukita		14. MOTHER'S MAIDEN NAME Marie	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-09-4015-A	
		17. INFORMANT (Wife) Box 254X North Point Rd. Mrs. Ann Pukita, Baltimore, Md. 21219	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CONGESTIVE HEART FAILURE	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO, OR AS A CONSEQUENCE OF:	
		OLD MYOCARDIAL INFARCTION	
		ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		GENERALIZED ARTERIO-SCLEROTIC DISEASE	
		(C) CEREbro-VASCUlar ACCIDENT - OLD LEFTSIDED PARALYSIS, SEVERE MALNUTRITION AND DEHYDRATION	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 2	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) Yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At <input type="checkbox"/> Work	21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 9-16 1972 to 9-18 1972 that (I) last saw the deceased alive on 9-18 1972 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.			
23A. SIGNATURE Julius Tosheff, M.D.		23B. DATE SIGNED 9-18-1972	
23C. PHYSICIAN'S NAME (Type) JULIUS TOSHEFF, M.D.		23D. ADDRESS 2025 Woodbourne Ave, Baltimore, Md. 21239	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 9-21-72	24C. NAME OF CEMETERY OR CREMATORY Sacred Heart of Mary Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. SEP 22 1972	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR John J. Duda 7922 Wise Ave. Dundalk, Md. 21222	

8

RP



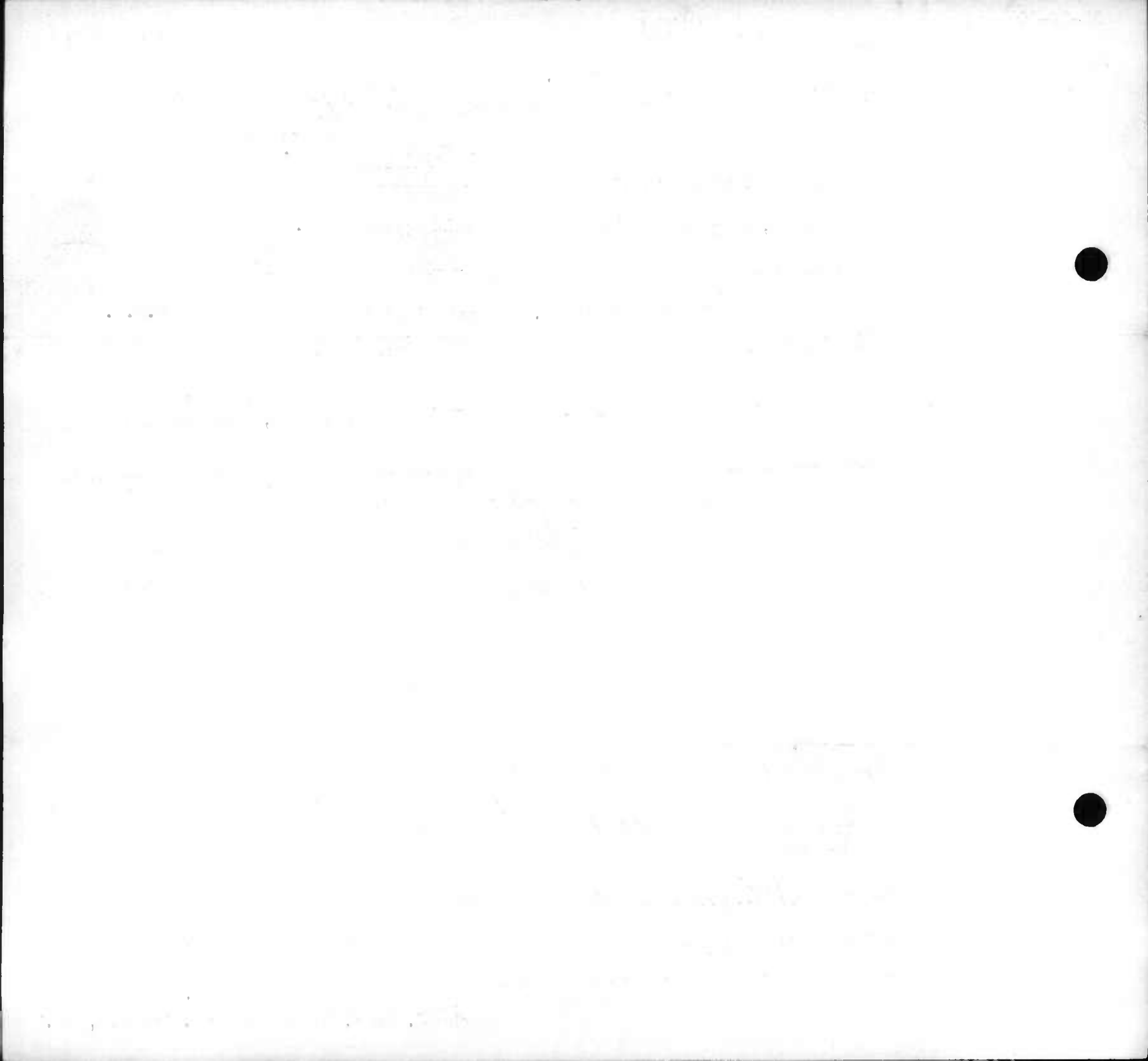
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>R-220</b>      <b>72 09068</b>      <b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p style="font-size: 1.2em; font-weight: bold;">CERTIFICATE OF DEATH</p>		<p>REG. NO. <b>72 09068</b></p> <p>STATE OF <b>MARYLAND-DHMH</b></p>	
<p>BIRTH NO. <b>R-220</b></p> <p>1. NAME OF DECEASED (Type or Print) <b>Nellie Rokszewicz</b></p>		<p>2. DATE AND HOUR OF DEATH <b>September 18, 1972 4:22 P.M.</b></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p><b>HARBOR VIEW NURSING HOME</b> <b>1213 LICAT ST. BALTO MD 21230</b></p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</p> <p>A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b></p> <p>C. CITY OR TOWN <b>Dundalk</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> <p>E. STREET AND NUMBER <b>205 Maple Avenue</b></p>	
<p>5. SEX <b>Female</b></p>	<p>6. RACE <b>White</b></p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <b>5-9-98</b></p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p><b>Housewife</b></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>	<p>11. BIRTHPLACE (State or foreign country) <b>Poland</b></p>
<p>13. FATHER'S NAME <b>Frank Pilney</b></p>		<p>14. MOTHER'S MAIDEN NAME <b>Mary</b></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p> <p><b>No</b></p>	<p>16. SOCIAL SECURITY NO. <b>354-12-5241</b></p>	<p>17. INFORMANT <b>Son: Mr. Edward T. Rokszewicz</b> ADDRESS <b>205 Maple Avenue Dundalk, Md. 21222</b></p>	
<p>18. <b>412.31</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>CAUSE OF DEATH</p> <p>(A) IMMEDIATE CAUSE <b>Coronary Artery</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Sudden</b></p> <p>(B) <b>AS-C.V. Disease</b> DUE TO, OR AS A CONSEQUENCE OF: <b>?</b></p> <p>(C) <b>Old M.T.</b> DUE TO, OR AS A CONSEQUENCE OF: <b>?</b></p>	
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No) <b>No</b></p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour)</p>	
<p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <b>9/16</b> 19 <b>72</b> to <b>9/18</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>9/16</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <b>Joseph S. Blum</b></p>		<p>23B. DATE SIGNED</p>	
<p>23C. PHYSICIAN'S NAME (Type) <b>JOSEPH S. BLUM</b></p>		<p>23D. ADDRESS <b>1115 N. CALVERT ST</b></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b></p>	<p>24B. DATE <b>9-21-72</b></p>	<p>24C. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith Cemetery</b></p>	<p>24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b></p>
<p>25A. DATE REC'D BY HEALTH DEPT. <b>SEP 22 1972</b></p>		<p>25B. NAME OF REGISTRAR <b>John J. Duda</b></p>	
<p>25C. FUNERAL DIRECTOR <b>John J. Duda</b></p>		<p>25D. ADDRESS <b>2022 Wise Ave Dundalk Md. 21222</b></p>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

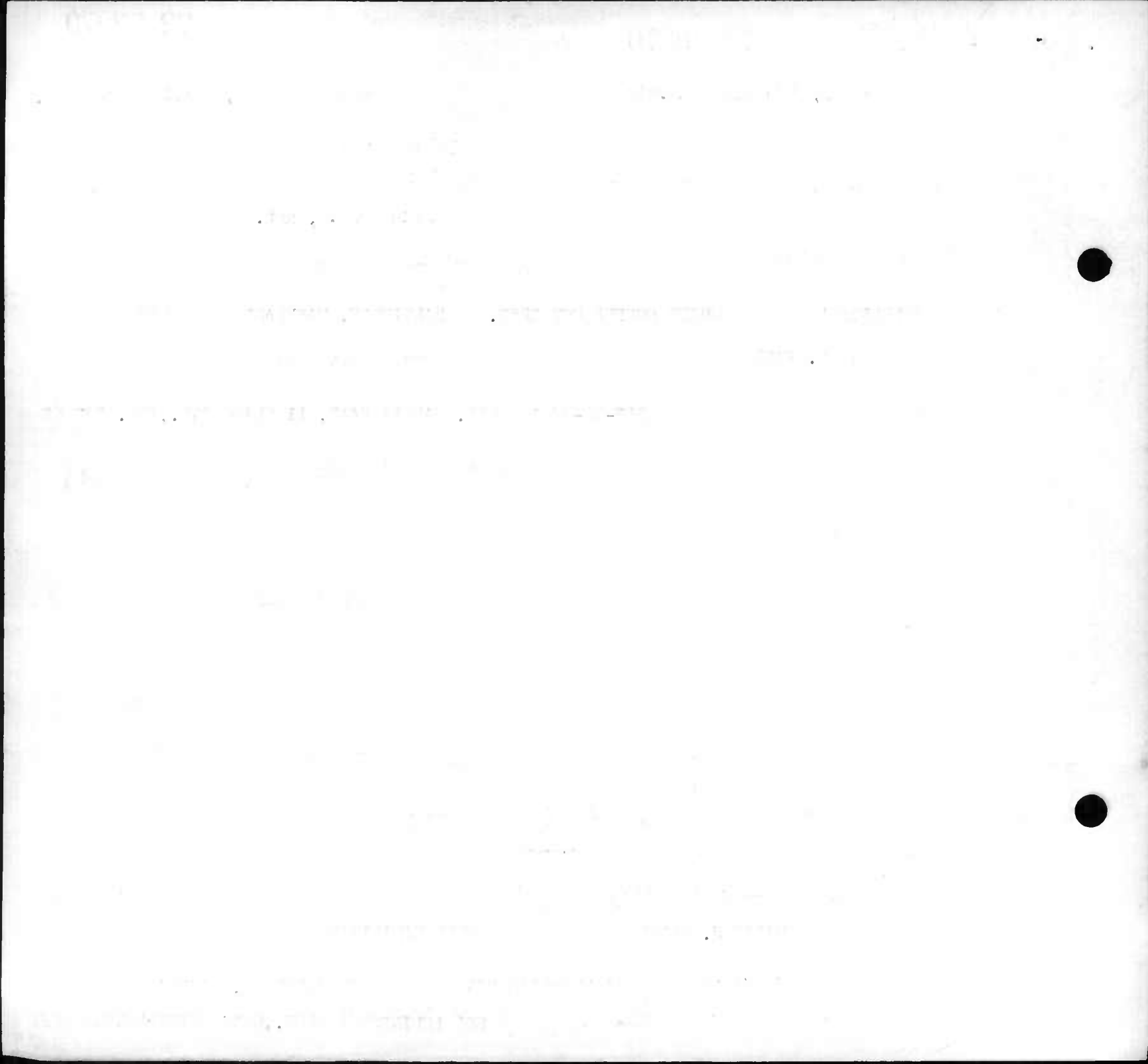
B-760		72 09069		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09069	
BIRTH NO.				STATE OF MARYLAND - DEATH			
1. NAME OF DECEASED (Type or Print) <b>BUBER, OSCAR</b>				2. DATE AND HOUR OF DEATH <b>9/17/72 2:10 PM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</b>				A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>2712 Sparrows Pt. Rd 21219</b>			
5. SEX <b>Male</b>		6. RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-9-20</b>	
9. AGE (In years last birthday) <b>52</b>		10. UNDER 1 Yr. Months: Days: Hours: Min.		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bethlehem Steel Co.</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>West Virginia</b>			
13. FATHER'S NAME <b>Clithero Buba</b>				14. MOTHER'S MAIDEN NAME <b>Olive Murray</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WWII</b>		16. SOCIAL SECURITY NO. <b>215-18-5391</b>		17. INFORMANT <b>BCH-Records</b>		ADDRESS <b>4904 Eastern Avenue Baltimore, Maryland 21224</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(A) IMMEDIATE CAUSE: Pulmonary infarct DUE TO, OR AS A CONSEQUENCE OF: suspected CVA &amp; coma aspiration pneumonia (B) DUE TO, OR AS A CONSEQUENCE OF: pepsia (C) chronic alcoholism</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 hrs 6 days 6 days 2 days over 30 yrs</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>9/17/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>N/D</b>		20A. AUTOPSY? (Yes or No) <b>N/D</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <b>9/11</b> 19 <b>72</b> to <b>9/17</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>9/17</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Hiroschi Mitsumoto, M.D.</b>				23B. DATE SIGNED <b>9/17/72</b>		23C. PHYSICIAN'S NAME (Type) <b>HIROSHI MITSUMOTO, M.D.</b>	
23D. ADDRESS <b>4940 E. Ave. BCH, Balto</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>					
24B. DATE <b>9/21/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Nicholson Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Morgantown, West Virginia</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 22 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Johnston</b>		25C. FUNERAL DIRECTOR <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

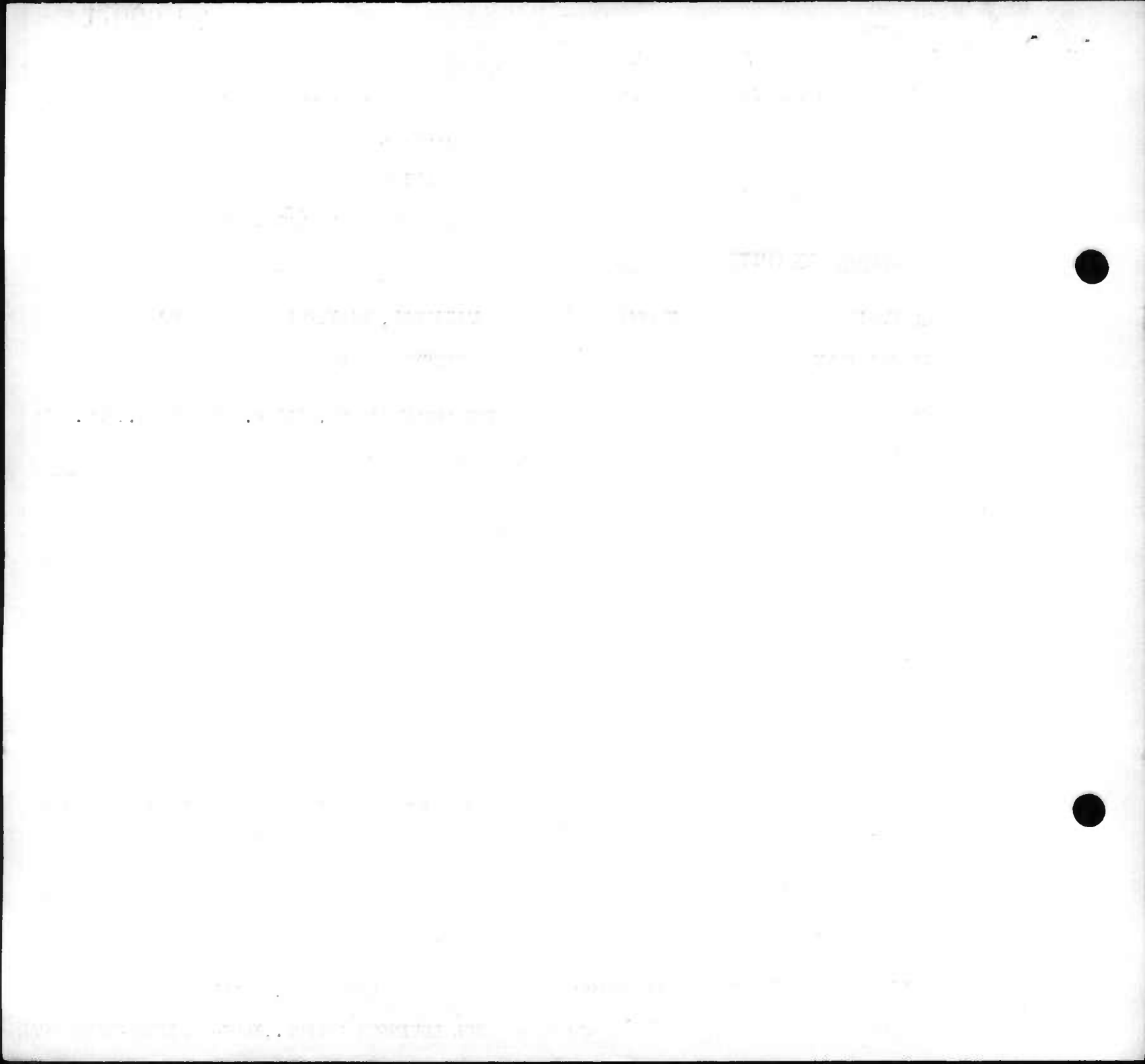
BALTIMORE CITY HEALTH DEPARTMENT				72 09070		72 09070	
CERTIFICATE OF DEATH				REG. NO.			
1. NAME OF DECEASED (Type or Print) <b>Katz, Mitchell Louis</b>				2. DATE AND HOUR OF DEATH OF <del>MARYLAND-DEATH</del> <b>September 18, 1972 8:45 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>THE GOOD SAMARITAN HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>BALTO</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>11 Slade Ave., apt. 309</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>10-15-41</b>	9. AGE (In years last birthday) <b>30</b>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SUPERVISOR</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>WHITE COFFEE POT REST.</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jerome E. KATZ</b>				14. MOTHER'S MAIDEN NAME <b>Marcia Workman</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217-36-4401</b>		17. INFORMANT ADDRESS <b>MRS. MARCIA KATZ, 11 SLADE AVE., APT. 309 #8</b>			
18. CAUSE OF DEATH <b>340X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Multiple Sclerosis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 years</b>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Sept 18</b> 19 <b>72</b> to <b>19</b> and that (I) (we) last saw the deceased alive on <b>Sept 18</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Philip J. Burke MD</b>				23B. DATE SIGNED <b>Sept 18, 1972</b>		23C. PHYSICIAN'S NAME (Type) <b>PHILIP J. BURKE</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>9/20/1972</b>		24C. NAME OF CEMETERY or CREMATORY <b>BETH EL MEMORIAL PARK</b>		24D. LOCATION (City, town, or county) (State) <b>RANDALLSTOWN, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 22 1972</b>		25B. NAME OF REGISTRAR <b>Sidney [Signature]</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>			



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-526		BALTIMORE CITY HEALTH DEPARTMENT		72 09071	
BIRTH NO.		72 09071		REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		STATE OF MARYLAND-DHMH	
RACHAEL XXXXXX SINGER		16 Sept 1972 10:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL		A. STATE MARYLAND		B. COUNTY 1102	
		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 111 W. CENTER ST.			
5. SEX FEMALE	6. RACE XX WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/88	9. AGE (In years last birthday) 84	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
13. FATHER'S NAME ISRAEL LEVY		14. MOTHER'S MAIDEN NAME BETSYE ?		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MISS BETSY SINGER, 111 W. CENTRE ST., APT. 610	
18. 4/12.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CEREBROVASCULAR ACCIDENT (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 HRS	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 14 Sept 1972 to 16 Sept 1972 that (I) (we) last saw the deceased alive on 16 Sept 1972 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Karen M. Lichtenfeld MD		23B. DATE SIGNED 16 Sept 1972			
23C. PHYSICIAN'S NAME (Type) KAREN M. LICHTENFELD MD		23D. ADDRESS SINAI HOSP.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/19/72		24C. NAME OF CEMETERY or CREMATORY BNAI-ISRAEL	
25A. DATE REC'D BY HEALTH DEPT. SEP 22 1972		25B. NAME OF REGISTRAR Sedney Whorton		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 46010 REISTERSTOWN ROAD	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09072	
G-651 72 09072				STATE OF MARYLAND-DEMD	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		SINGAI GREENBERG		9-17-72 8:15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
SINGAI Hospital of Baltimore			MARYLAND		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore, Md.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 3605 OAKMONT AVENUE #21215		
			2798		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 Yr. Months Days
MALE	WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7-15-98	74	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEWIFE		AT HOME		HARTFORD, CONN.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
? KASPER			UNKNOWN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO				MRS. BERTHA STACKHOUSE, 3005 STRANDEN RD. #30	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			PNEUMONIC		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			A.S.L.V.D.		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-17-72 to 9-17-72 that (I) (we) last saw the deceased alive on 9-17-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Butterfield				9-17-72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. Butterfield MD				Singai Hospital Balto. Md.	
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
BURIAL		9/19/72		HEBREW ORTHODOX MEMORIAL SOCIETY, BALTIMORE, MARYLAND	
25A. DATE RECD BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
SEP 22 1972		Singer		SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	

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HARTFORD, CT.

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MR. HENRY H. HARRIS, 2000 STEVENSON ST., 100

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 72 09073 CERTIFICATE OF DEATH				REG. NO. 72 09073 STATE OF MARYLAND-DEME	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Cecilia Yeager</i>		2. DATE AND HOUR OF DEATH <i>September 30, 1972</i> 7 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Harbor View Nursing Home 1213 Light St Balto, Md</i>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>201</i>		
			C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <i>2017 Bank Street</i>		
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 1, 1883</i>	9. AGE (In years last birthday) <i>79</i>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Carl Jenkins</i>			14. MOTHER'S MAIDEN NAME <i>Margaret Brooks</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>220-09-8230</i>	17. INFORMANT <i>Mrs Rose Barrows</i> ADDRESS <i>2017 Bank Street</i>		
18. <i>519.3 I</i> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <i>Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF:  (B) <i>Chronic Obstructive Lung Disease</i> DUE TO, OR AS A CONSEQUENCE OF: <i>&amp; Cor Pulmonale</i>  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 Days</i>  <i>Years</i>  <i>Years</i>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Generalized ASCVD</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <i>August 31</i> 19 <i>72</i> to <i>September 21</i> 19 <i>72</i> that (H) (we) last saw the deceased alive on <i>September 21</i> 19 <i>72</i> and that (H) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Peter H Rheinstein, MD</i>			23B. DATE SIGNED <i>21 Sept 1972</i>		
23C. PHYSICIAN'S NAME (Type) <i>PETER H. RHEINSTEIN, MD</i>			23D. ADDRESS <i>621 HOLLY RIDGE RD, SEVERNA PARK</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>9-23-1972</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore County, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 22 1972</i>		25B. NAME OF REGISTRAR <i>Andrew Johnston</i>		25C. FUNERAL DIRECTOR <i>Lilly &amp; Zeiler Inc.</i> ADDRESS <i>1901-07 Eastern Ave.</i>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 09074

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 72 09074

STATE OF MARYLAND-DHMH

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MINNIE HILTZ

2. DATE AND HOUR OF DEATH

SEPT. 21 1972 5:15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

SOUTH BALTIMORE GEN'L HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE B. COUNTY

MARYLAND BALTIMORE CITY 2403

C. CITY OR TOWN D. INSIDE CITY LIMITS?

BALTIMORE YES ☒ NO ☐

E. STREET AND NUMBER

1213 LIGHT STREET HARBOR VIEW

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

11-19-94

9. AGE (in years last birthday)

78

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

NONE

10B. KIND OF BUSINESS OR INDUSTRY

HOUSE WIFE

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

(JOHN)? YEAGER

14. MOTHER'S MAIDEN NAME

IDA (UNKNOWN LAST NAME)

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

213-05-3320

17. INFORMANT

ADDRESS

Vernon LeBrun 3137 Baybriar Road

18. 436.914250.9 CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE ASPIRATION PNEUMONIA 1 DAY  
DUE TO, OR AS A CONSEQUENCE OF:

(B) R-SIDED CVA THREE WEEKS  
DUE TO, OR AS A CONSEQUENCE OF:

(C) DEHYDRATION THREE WEEKS +

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

DIABETES MELLITIS 15 + years

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (H) (this hospital) attended the deceased from AUGUST 31 1972 to SEPTEMBER 21 1972 that (H) (we) lost saw the deceased alive on SEPTEMBER 21 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Theodore H. Cryer M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

9-21-72

23C. PHYSICIAN'S NAME (Type)

THEODORE H. CRYER M.D.

23D. ADDRESS

S.B.G.H. 3001 S. HANOVER ST.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

9-25-1972

24C. NAME OF CEMETERY or CREMATORY

Oak Lawn

24D. LOCATION

Baltimore County, Maryland

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

SEP 22 1972

25B. NAME OF REGISTRAR

Sidney H. Hooton

25C. FUNERAL DIRECTOR

Lilly & Zeiler Inc. 1901-07 Eastern Ave.

ADDRESS

11 VNH 10, return 2311

27

2011 2711

Vernon Jackson 3333 Bayview Road

2011 2711

2011 2711

2011 2711

2011 2711

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 09075

BIRTH NO.

STATE OF MARYLAND-DEME

1. NAME OF DECEASED (Type or Print) Bedford Blue				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 9 19 72 1:50 A. M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy Hospital				3. DATE PRONOUNCED DEAD Month Day Year Hour 9 19 72 1:50 A. M.			
6. SEX Male				7. RACE Negro		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 1-5-18				10. AGE (In years last birthday) 54		11. BIRTHPLACE (State or foreign country) New Jersey	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Bedford Blue, Sr.			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER				14B. KIND OF BUSINESS OR INDUSTRY ?			
15. MOTHER'S MAIDEN NAME Judie Washington				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No			
17. SOCIAL SECURITY NO.				18. INFORMANT ADDRESS Mrs. Rose House 1638 Heathfield Rd.			
19. E 966X				CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE stabwound of chest DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(C)			
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) Yes				22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) sidewalk				22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 2 N. Frederick St.			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 9 19 72 1:00 A. M.				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			
22F. HOW DID INJURY OCCUR? found stabbed				23.			
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>				ACTUAL SIGNATURE William P. Mulloy, M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 9-22-72			
24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery				24D. LOCATION (City, town, or county) (State) Anne Arundel Co., Md.			
25A. DATE REC'D BY HEALTH DEPT. SEP 22 1972				25B. NAME OF REGISTRAR Sidney Whitworth			
25C. FUNERAL DIRECTOR ADDRESS Randolph J. Collick 2431 E. Oliver St.							

The first of the year was a very successful one for the  
company. The sales were up to the mark and the  
profits were also good. The management was very  
satisfied with the results and the staff was  
well pleased with the work they had done.

The second of the year was also a very successful one  
for the company. The sales were up to the mark and  
the profits were also good. The management was very  
satisfied with the results and the staff was well  
pleased with the work they had done.

The third of the year was also a very successful one  
for the company. The sales were up to the mark and  
the profits were also good. The management was very  
satisfied with the results and the staff was well  
pleased with the work they had done.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 09076

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO.

72 09076

STATE OF MARYLAND-DHMH

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

HOWARD A. NAQUIN

2. DATE AND HOUR OF DEATH

9/21/72 11:27 AM

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

JOHNS HOPKINS HOSP

33 BALTAORE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

BALT CITY

2712

C. CITY OR TOWN

BALT

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

2 SITTINGS AVE

5. SEX

M

6. RACE

W

7. MARRIED ☒

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

1-28-18

9. AGE (in years last birthday)

54

If Under 1 Yr. Months: Days: Hours: Min.

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

MEDICAL DOCTOR

10B. KIND OF BUSINESS OR INDUSTRY

MEDICINE

11. BIRTHPLACE (State or foreign country)

HAWAII

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

WALTER P. NAQUIN

14. MOTHER'S MAIDEN NAME

ETHEL KEATING

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

YES

16. SOCIAL SECURITY NO.

NAVY-WW II 658-16-8535

17. INFORMANT

J K Brown MD

ADDRESS

JH H

18. 200.01

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

Severe aspiration pneumonia

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Giant cell lymphoblastoma

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

3 days

8 years.

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

Renal failure, hepatic failure

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

NO

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 9/18/72 19 to 9/21 1972 that (I) (we) last saw the deceased alive on 9/21 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

James K. Brown MD

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

9/21/72

23C. PHYSICIAN'S NAME (Type)

James K. Brown,

M.D. DEGREE

23D. ADDRESS

The Johns Hopkins Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)

Cremation

24B. DATE

9-22-72

24C. NAME of CEMETERY or CREMATORY

Greenmount

24D. LOCATION

Balto.,

(City, town, or county)

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

SEP 22 1972

25B. NAME OF REGISTRAR

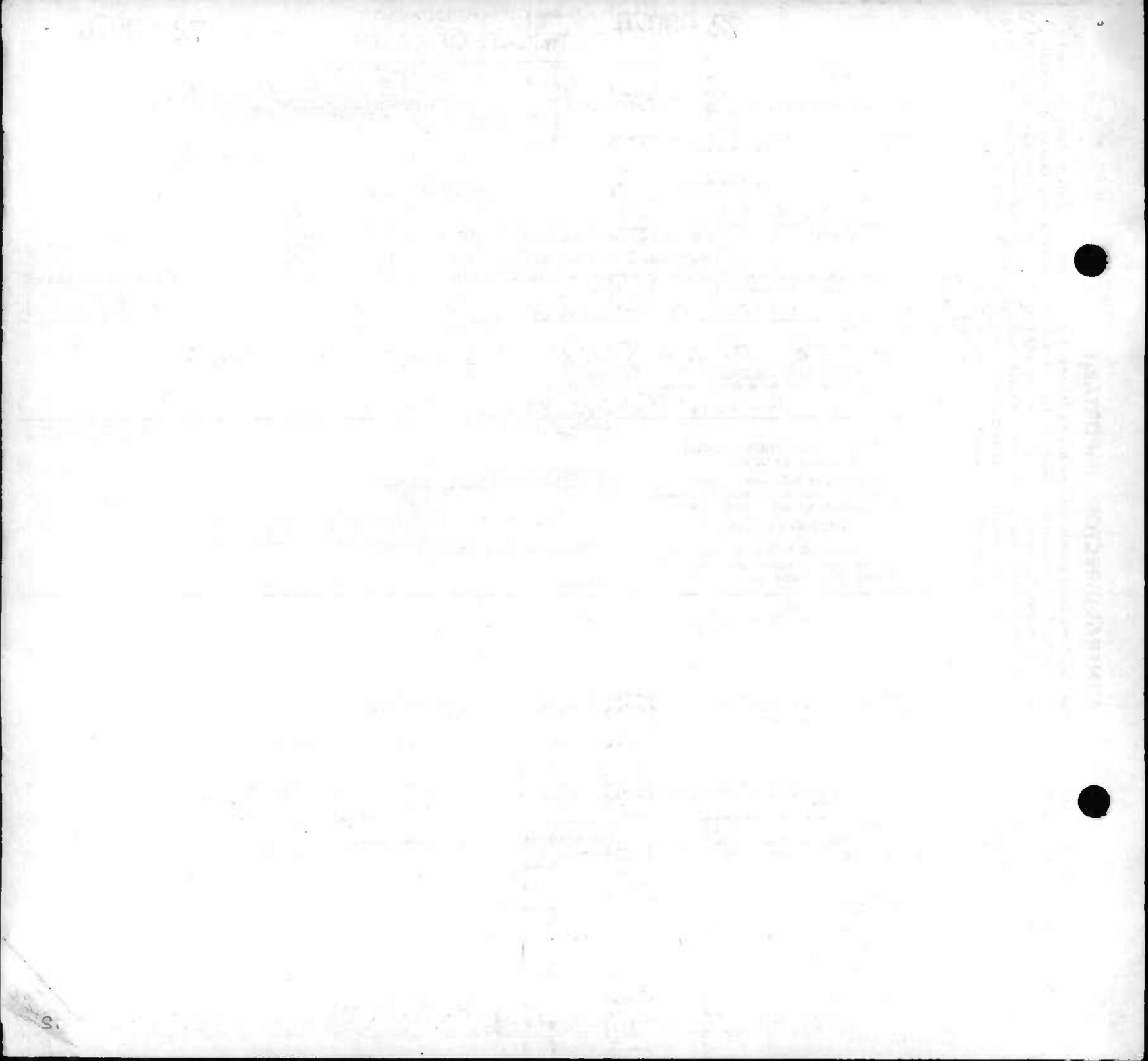
Sidney W. Boston

25C. FUNERAL DIRECTOR

H. W. Jenkins & Sons Co.

ADDRESS

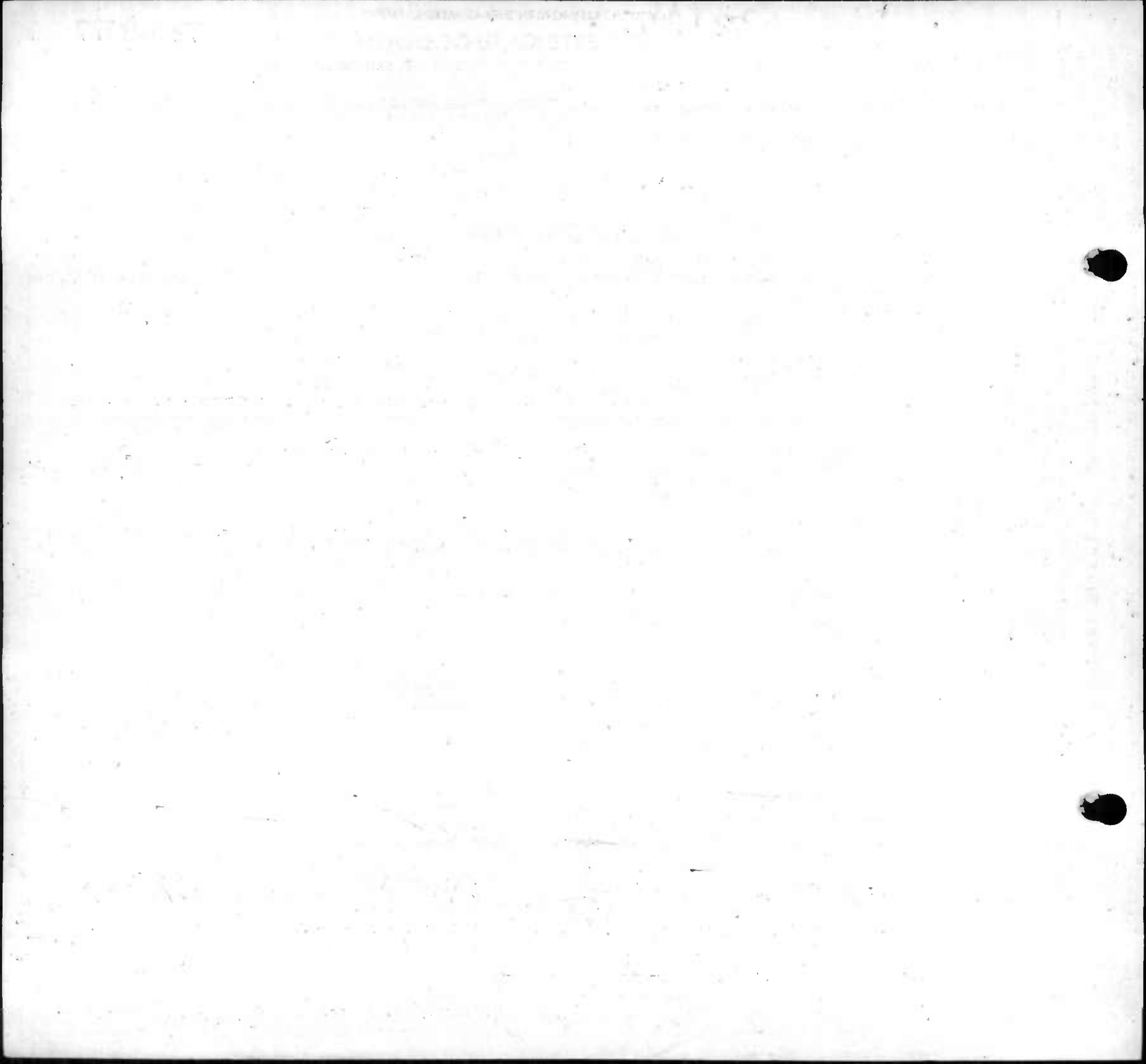
4905 York Road Balto., Md. 21212



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

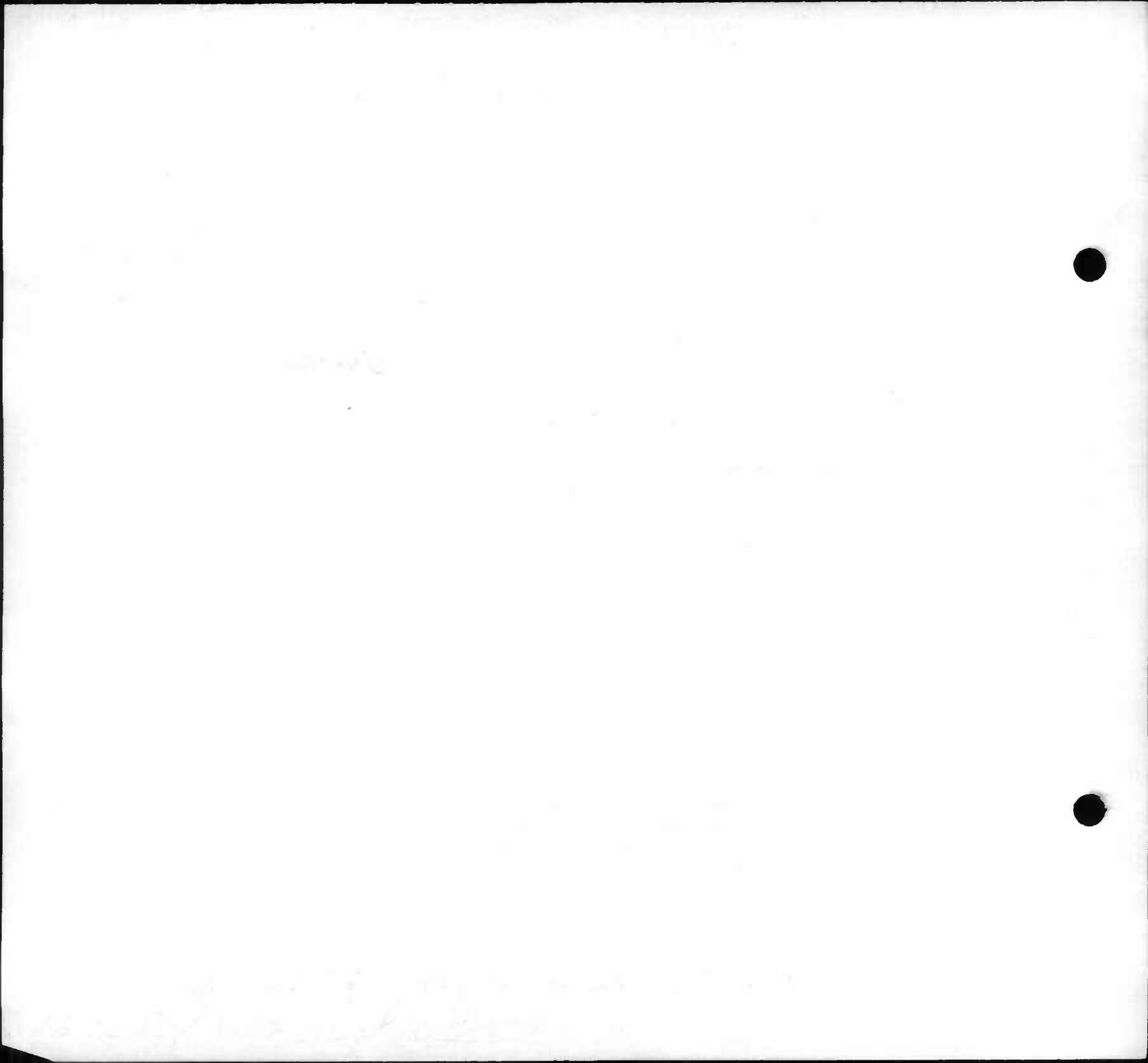
72 09077				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09077	
BIRTH NO.				STATE OF MARYLAND-DEME			
1. NAME OF DECEASED (Type or Print) Alice G. Plaisted				2. DATE AND HOUR OF DEATH 9-20-72 7 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY 2713			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Long Green N. H.				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 5506 Roland Ave.		21210	
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-28-1898	9. AGE (In years last birthday) 74	10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker			10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Spokane, Washington		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Edgar Graves			14. MOTHER'S MAIDEN NAME Hallie Davis				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 551-09-7125-D		17. INFORMANT ADDRESS Mrs. William H. Wilson Jr. Same		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Cerebral Arteriosclerosis (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Generalized arteriosclerosis 2 yr. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 mo.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3/4 1950 to 9/20 1972 that (I) (we) last saw the deceased alive on 9/17 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
23A. SIGNATURE Norman R. Freeman, Jr.				23B. DATE SIGNED 9/21/72			
23C. PHYSICIAN'S NAME (Type) Norman R. Freeman, Jr. M.D.				23D. ADDRESS 11 W. 29th St.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-23-72		24C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		24D. LOCATION (City, town, or county) (State) Pikesville, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 22 1972		25B. NAME OF REGISTRAR Audrey B. Heston		25C. FUNERAL DIRECTOR Henry W. Jenkins Sons		ADDRESS 4905 York Rd. Baltimore, Md. 21212	



FUNERAL DIRECTOR: IMPORTANT

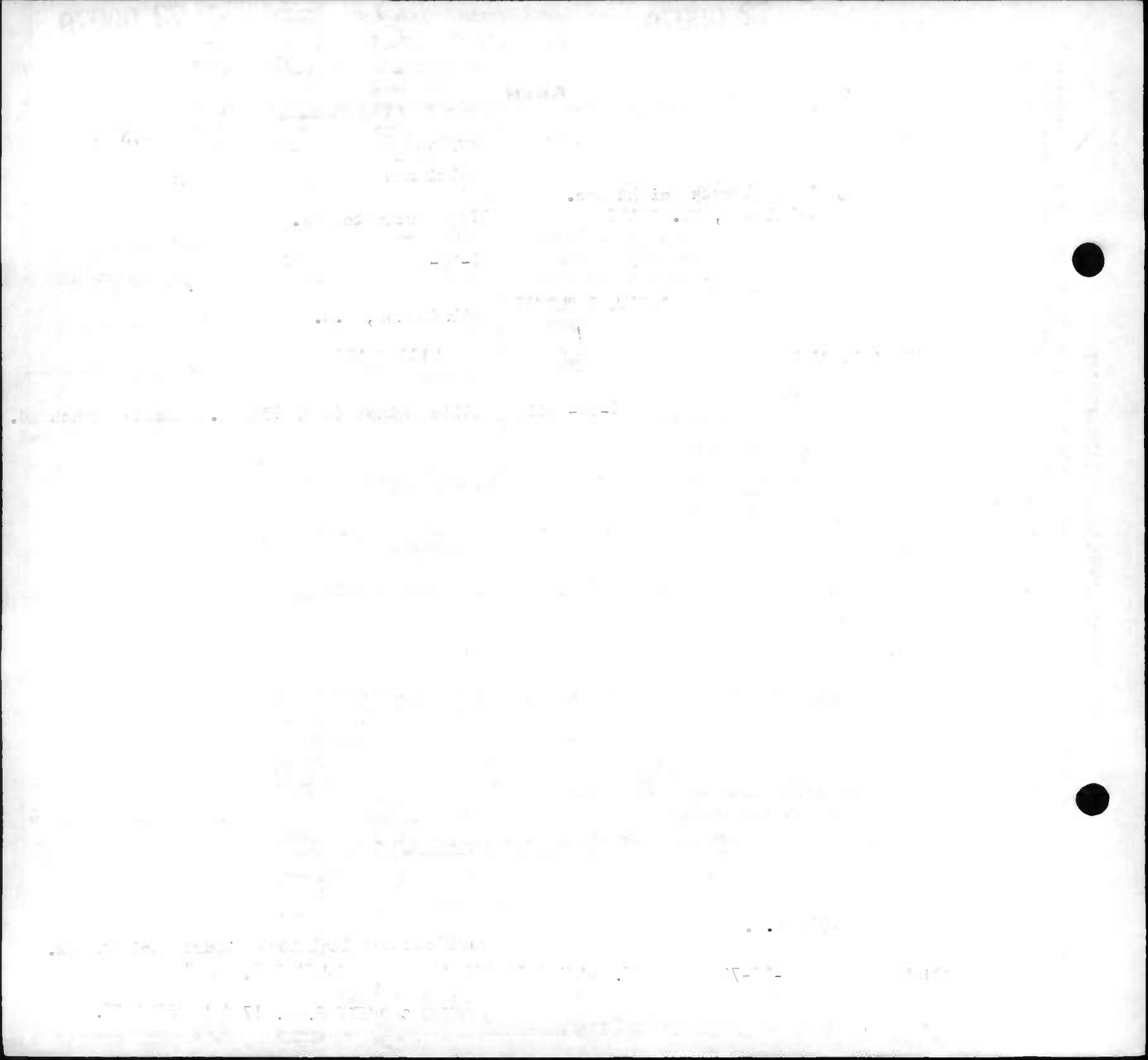
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-234		72 09078		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09078	
BIRTH NO.		CERTIFICATE OF DEATH				STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
McDOWELL, CLAREDON G		9-19-72 12.30. A.M.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 602			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN		D. INSIDE CITY LIMITS?			
CHURCH HOME & HOSPITAL		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
35		E. STREET AND NUMBER		2400 E. FAIRMOUNT AVE.			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12-4-1900	71			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
BETH. STEEL WORKER STEEL				PA.		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
HARRY R. McDowell		UNKNOWN		No			
16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
291-07-8034		PEARL McDOWELL		2400 E. FAIRMOUNT Ave. BALT., MD. 21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Cerebrovascular Accident					
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Arteriosclerosis, Diabetes mellitus.					
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) _____					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (the hospital) attended the deceased from 9-3-1972 to 9-19-1972 that (H) (we) last saw the deceased alive on 9-18-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)			
Jung Ho Kim		9-18-72		A. PAULINO M.D.			
A. PAULINO		DEGREE		23D. ADDRESS			
JUNG-HO KIM M.D.				CHURCH HOME & HOSPITAL			
A. PAULINO M.D.		DEGREE		BALTIMORE, MD. 21231			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		9-22-72		GARDENS OF FAITH Cem.		BALTO., MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
SEP 22 1972		Audrey In...		H. Miller - 2334		Jefferson St	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
72 09079				72 09079	
N-250					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <i>Nixon Summer ORRIN</i>			2. DATE AND HOUR OF DEATH <i>9-20-1972</i>   <i>9-30 P.M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Provident Hosp. Inc.</i> <i>39</i>			A. STATE <i>Maryland</i>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>2600 Liberty Height Ave.</i> <i>Baltimore, Md. 21217</i>			C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <i>M</i>			6. RACE <i>N</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>7-20-88</i>			9. AGE (in years last birthday) <i>84</i>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY <i>POSTAL EMPLOYEE</i>		11. BIRTHPLACE (State or foreign country) <i>Wilmington, N.C.</i>
12. CITIZEN OF WHAT COUNTRY <i>USA</i>			13. FATHER'S NAME <i>HENRY SAMPSON</i>		
14. MOTHER'S MAIDEN NAME <i>ALICE BRISCO</i>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		
16. SOCIAL SECURITY NO. <i>217-38-2033</i>			17. INFORMANT <i>William Nixon (SON) 7369 E. Furance Branch Rd.</i>		
18. <i>136.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Massive Internal Hemorrhage Two days.</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Recurrent CA of Common Bile Duct</i>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Recurrent CA of Common Bile Duct</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Deep jaundice</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>-</i>					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>8-31-1972</i> to <i>9-20-1972</i> that (I) (we) last saw the deceased alive on <i>9-20-1972</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Ujala M.D.</i> M.D. DEGREE				23B. DATE SIGNED <i>9-20-72 9-45 PM</i>	
23C. PHYSICIAN'S NAME (Type) <i>Ujala M.D.</i>				23D. ADDRESS <i>Provident Hospital 2600 Liberty Height Ave.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>9-25-72</i>		24C. NAME OF CEMETERY or CREMATORY <i>MT. AUBURN CEMETERY</i>	
24D. LOCATION <i>BALTIMORE, MARYLAND</i>		24E. NAME OF REGISTRAR <i>SEP 22 1972 Sidney H. Weston</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 22 1972</i>		25B. NAME OF REGISTRAR <i>Sidney H. Weston</i>		25C. FUNERAL DIRECTOR <i>MORTON &amp; DYETT F. H. 1701 LAURENS ST.</i>	





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 09080

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>EUGENE MARTIN</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> <b>September 21, 1972</b>		Hour <b>M.</b>
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Maryland General Hospital (DOA)</b>		3. DATE PRONOUNCED DEAD Month <b>September</b> Day <b>21</b> Year <b>1972</b>		Hour <b>10:20A</b> M.
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2001</b>				
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH <b>SEPT 25, 1906</b>	10. AGE (In years last birthday) <b>65</b>	11. BIRTHPLACE (State or foreign country) <b>ATLANTA, GEORGIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CONSTRUCTION</b>		15. MOTHER'S MAIDEN NAME <b>WILLIE MARTIN</b>		
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		17. SOCIAL SECURITY NO.		
18. INFORMANT <b>MRS. ADDIE MARTIN</b>		ADDRESS <b>1905 W. FAYETTE ST.</b>		
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Multiple injuries</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION <b>21</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>Yes</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>building</b>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>Construction-601 Cathedral Street</b>
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>9-21-72 10:00 A.</b>		22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Fell off scaffold, landing on cement floor</b>
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Marvin S. Platt</b> M.D. EXAMINER'S NAME (Type) <b>Marvin S. Platt, M.D.</b> DATE SIGNED <b>September 21, 1972</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>9-25-72</b>	24C. NAME of CEMETERY or CREMATORY <b>ARBUTUS MEMORIAL PK.</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 22 1972</b>		25B. NAME OF REGISTRAR <b>Aidy H. Koston</b>		25C. FUNERAL DIRECTOR ADDRESS <b>MORTON &amp; BYETT F. H. 1701 LAURENS ST.</b>

10-2-1972 - Correction Form from Funeral Director - Leroy O. Dyett, Morton & Dyett  
Funeral Home, Balto., Md. HRS

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09081		72 09081	
CERTIFICATE OF DEATH				REG. NO.		STATE OF MARYLAND-DEM	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
WILSON, GEORGE W.		9/20/72 11 PM.		SOUTH BALTIMORE GENERAL HOSPITAL		HARBOR MARYLAND 2403	
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
M		B		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9-12-09 63	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				S. CAROLINA		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
CEASAR (dec.)				LISSA (dec.) Wilson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
		251-14-2457A		Louise Wilson - 3808 - Bayview Ave			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		19. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE				Terminal Ca of prostate with metastases	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(APPROX)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 8/30 1972 to 9/20 1972 that (I) (we) last saw the deceased alive on 9/20 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
A. Korman M.D.				9/20/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		9-25-72		Harbortus Mem Pk.		Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
SEP 22 1972		Sidney [Signature]		Morton + Dyett F.H. 1701 - Harbortus		St.	

H V. N H to retain call

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STATE OF MARYLAND - DEPT. OF HEALTH				BALTIMORE CITY HEALTH DEPARTMENT			
72 09082				MEDICAL EXAMINER'S CERTIFICATE OF DEATH			
BIRTH NO. 69-10171				REG. NO. 72 09082			
1. NAME OF DECEASED (Type or Print) <b>RUSSIA HOLLEY 2ND</b>				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>St. Agnes Hospital (DOA)</b>				3. DATE PRONOUNCED DEAD Month Day Year <b>9-19-1972</b> Hour <b>9:45 p.m.</b>			
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2864</b>							
6. SEX <b>male</b>	7. RACE <b>negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>JUNE 6, 1969</b>		10. AGE (In years last birthday) <b>3</b>		E. STREET AND NUMBER <b>102 Diener Ave. Apt. 302</b>			
11. BIRTHPLACE (State or foreign country) <b>BALTO, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>RUSSIA HOLLEY</b>			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY <b>CHILD</b>		15. MOTHER'S MAIDEN NAME <b>FERNETTA JOHNSON</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS <b>RUSSIA HOLLEY 102 DIENER PLACE</b>			
19. CAUSE OF DEATH <b>E9631X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Strangulation</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION <b>9-20-72</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>woods</b>		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>4300 blk. Connecticut Ave. 2864</b>			
22D. TIME OF INJURY (APPROX.) Month Day Year <b>9-19-72</b>		22E. INJURY OCCURRED While at work <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Subject strangled.</b>			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> <b>9-20-72</b> ACTUAL SIGNATURE <b>Marvin S. Platt</b> M.D. EXAMINER'S NAME (Type) <b>Marvin S. Platt, M.D.</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>9-23-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>WESTERN STAR CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
25A. DATE RECEIVED BY HEALTH DEPT. <b>SEP 22 1972</b>		25B. NAME OF REGISTRAR <b>William H. Heston</b>		25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F. H.</b>		ADDRESS <b>1701 LAURENS STREET</b>	

10-10-1972 - Letter from the Office of the Chief Medical Examiner,  
Marvin S. Platt, M.D. HRS



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S-513

72 09083

STATE OF MARYLAND-DHMH

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 09083

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) David Sumpter		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 9 Day 16 Year 72 Hour 12:50A M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 University Hospital		3. DATE PRONOUNCED DEAD Month 9 Day 16 Year 72 Hour 12:50A M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1801	
9. DATE OF BIRTH 7/16/15		10. AGE (In years last birthday) 57	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY U.S.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 250-16-2547	
18. INFORMANT Mary Mcallister		ADDRESS	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 900 blk. W. Fayette St. 74' W. of Amity St.		22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 8 17 72 8:50 Pm.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Pedestrian struck by auto 1801	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE William P. Mulloy, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) William P. Mulloy, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9-17-72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/21/72	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Westport, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 22 1972		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR Charles A. Rice		ADDRESS 1300 N. Eutaw Pl.	

15 13003

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 09084

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Abraham Campbell, Jr.</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <b>9</b> Day <b>18</b> Year <b>72</b> Hour <b>M.</b>			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>00 2635 Garrett Avenue</b>				3. DATE PRONOUNCED DEAD Month <b>9</b> Day <b>18</b> Year <b>72</b> Hour <b>8:15 a.</b>			
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>907</b>				C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
6. SEX <b>male</b>		7. RACE <b>Negro</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <b>2635 Garrett Avenue</b>	
9. DATE OF BIRTH <b>Mar. 14, 1932</b>		10. AGE (in years last birthday) <b>40</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Abraham Campbell</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		15. MOTHER'S MAIDEN NAME <b>Lillian Connish</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO. <b>220-16-3977</b>		18. INFORMANT <b>Dennette Tyson</b>		19. CAUSE OF DEATH <b>Hypertensive and arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(C)			
20A. DATE OF OPERATION <b>2</b>				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Cirrhosis of liver and epilepsy</b>			
21. AUTOPSY? (Yes or No) <b>yes</b>							
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?				22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)			
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Peter Lipkovic, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>9/18/72</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-23-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Calvary Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Brooklyn Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 22 1972</b>		25B. NAME OF REGISTRAR <b>Adriana Houston</b>		25C. FUNERAL DIRECTOR <b>Chas. O. Wilson</b>		ADDRESS <b>1000 Bentley Ave.</b>	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 09085

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 72 09085

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Webster Brunson, Sr.

2. DATE AND HOUR OF DEATH  
September 20, 1972

for each Transcript

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

1343 Division Street -  
Baltimore, Maryland 21217

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

1343 Division Street

5. SEX

Male

6. RACE

Negro

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

March 24, 1903

9. AGE (In years last birthday)

69

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Robin Brunson

14. MOTHER'S MAIDEN NAME

Henriatta Lawson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

216-07-6114 A

17. INFORMANT

ADDRESS

Mrs. Lucinda Brunson 1343 Division Street

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

cerebral thrombosis

(B)

DUE TO, OR AS A CONSEQUENCE OF:

cerebral arteriosclerosis

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

4 hrs.

17 yrs

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

① diabetes ② arteriosclerosis obliterans ③ 30 yrs ④ 3 years

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from June 71 19 to Sept 19 1972 that (I) (we) last saw the deceased alive on Sept 19 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Ralph H. Twining Jr.

DEGREE

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

Sept 21, 1972

23C. PHYSICIAN'S NAME (Type)

RALPH H. TWINING, JR., M.D.

DEGREE

23D. ADDRESS

407 EDMONDSON AVE. BALTIMORE, MD.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

9-23-72

24C. NAME OF CEMETERY OR CREMATORY

Cedar Hill Cemetery

24D. LOCATION

A. A. Co., Maryland

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

SEP 22 1972

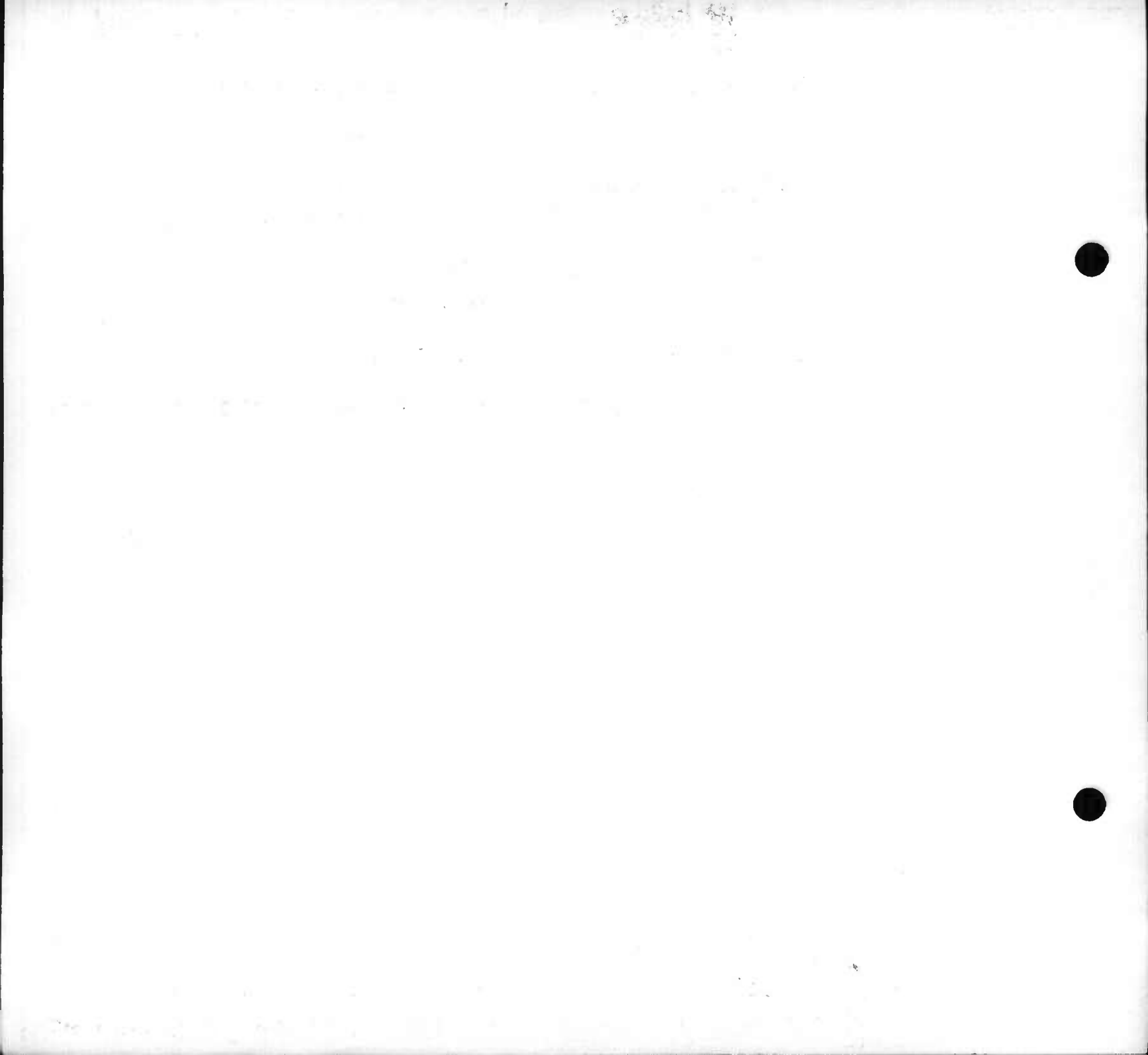
25B. NAME OF REGISTRAR

Sidney W. Boston

25C. FUNERAL DIRECTOR

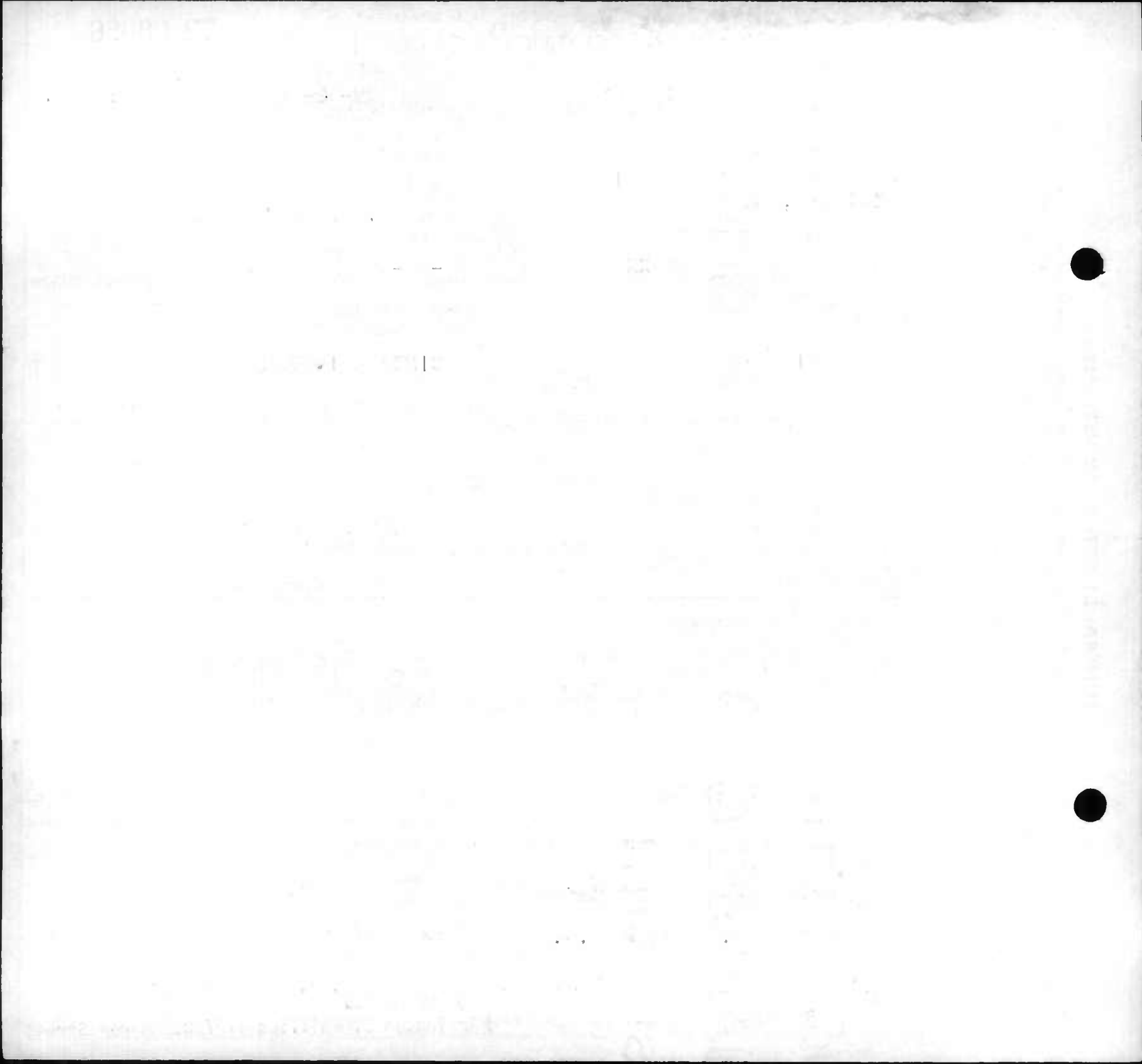
Arlington S. Phillips 1727 N. Monroe Street

ADDRESS



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

MORTUARY CITY HEALTH DEPARTMENT				REG. NO. <b>72 09086</b>	
BIRTH NO. <b>72-9086</b>				STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print) <b>ELEANOR TINSLEY</b>			2. DATE AND HOUR OF DEATH <b>09-16-72 8:20 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2710</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>4448 ST. GEORGE'S AVE</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>08-26-14</b>	9. AGE (In years last birthday) <b>58</b>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>EUGENE TINSLEY</b>		
14. MOTHER'S MAIDEN NAME <b>LUCONDA HAIRSTON</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO.			17. INFORMANT <b>Mr. Purcell Tinsley 4448 St. George's Ave.</b>		
18. CAUSE OF DEATH <b>PERITONITIS.</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(A) SMALL BOWEL PERFORATION, OBST.</b> <b>(B) METASTATIC CARCINOMATOSIS</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>36 HRS.</b> <b>3 mos.</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>9-14-72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Small Bowel Obstruction</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>Sept 13-22</b> 19 <b>72</b> to <b>Sept 16</b> 19 <b>72</b> that (2) (we) last saw the deceased alive on <b>9/16</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (3) (We) (did) (not) view the body after death.					
23A. SIGNATURE <b>Charles E. Pappas M.D.</b>				23B. DATE SIGNED <b>9/17/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>CHARLES E. PAPPAS M.D.</b>				23D. ADDRESS <b>JOHNS HOPKINS UNIV. HOSPITAL</b>	
24A. BURIAL-CREATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-20-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>	
24D. LOCATION <b>A. A. Co., Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 22 1972</b>			
25B. NAME OF REGISTRAR <b>Sidney Johnston</b>		25C. FUNERAL DIRECTOR <b>Arlington S. Phillips 1727 N. Monroe Street</b>			



BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ANNA D. THEINER

2. DATE  
OF  
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

00 3407 E. Lombard St.

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

9

19

1972

7:25p

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md.

B. COUNTY

2608

6. SEX

female

7. RACE

white

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Bato.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

6/24/1897

10. AGE (In years  
last birthday)

75

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

3407 E. Lombard St.

11. BIRTHPLACE (State or foreign country)

Colbert, Washington

12. CITIZEN OF  
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

PAUL THEINER

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Children's nurse

14B. KIND OF BUSINESS OR INDUSTRY

Private Home

15. MOTHER'S MAIDEN NAME

Emma Rokette

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

217-14-9837

18. INFORMANT

Im Bernhard Theiner

ADDRESS

RD #1  
Brook Park 17308

19.

41241

CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Ronald N. Kornblum, M.D.

Deputy Chief Medical Examiner

DATE SIGNED

9-20-72

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

9/22/72

24C. NAME OF CEMETERY or CREMATORY

St Jacob's Stone Church

24D. LOCATION (City, town, or county)

Brook Park, York Co. Pa.

(State)

25A. DATE REC'D BY HEALTH DEPT

SEP 22 1972

25B. NAME OF REGISTRAR

Sidney W. Horton

25C. FUNERAL DIRECTOR

5808 E. Glen Rock, Pa. 17327

ADDRESS

5808 E. Glen Rock, Pa. 17327

TS UNIT

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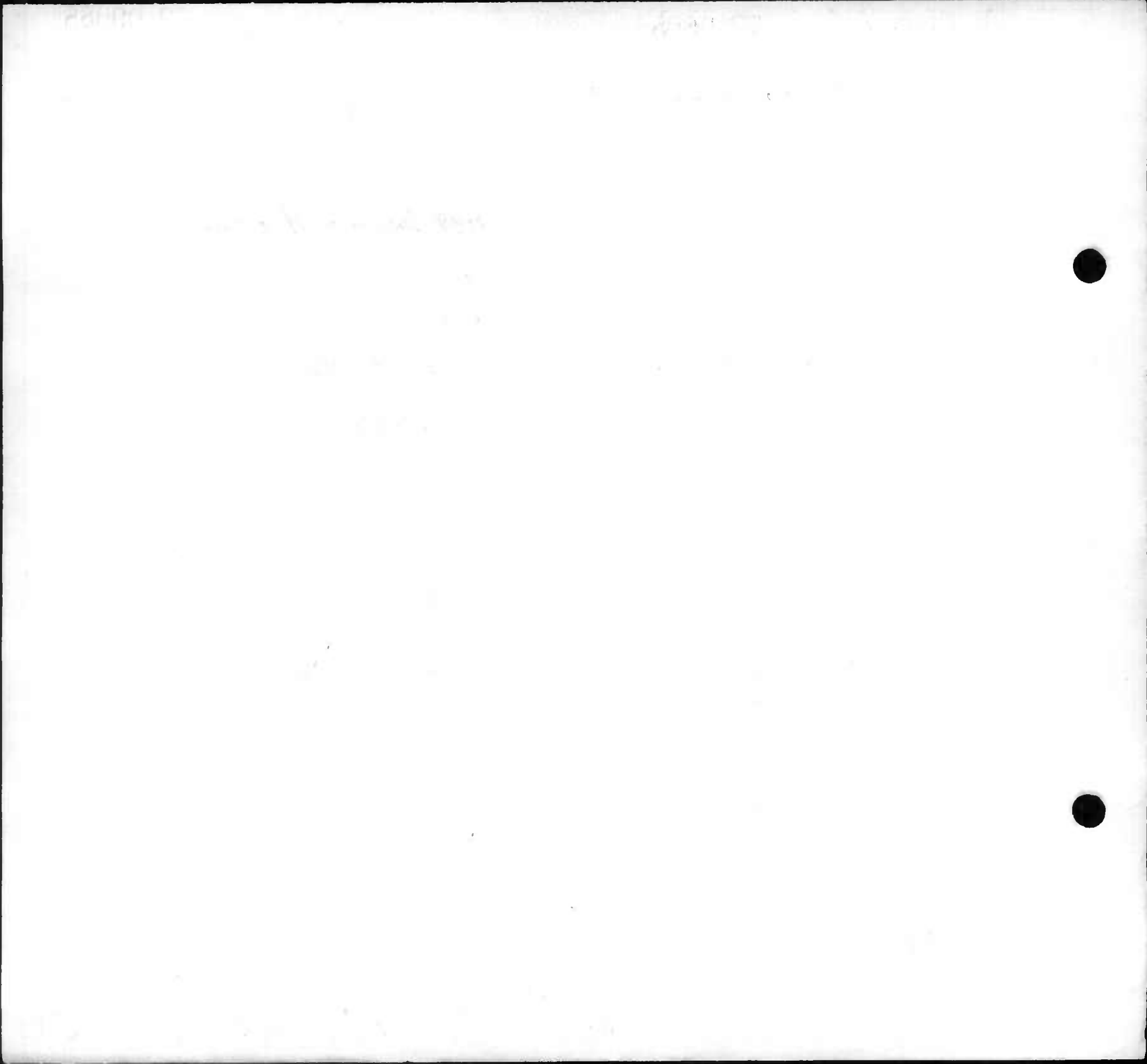
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

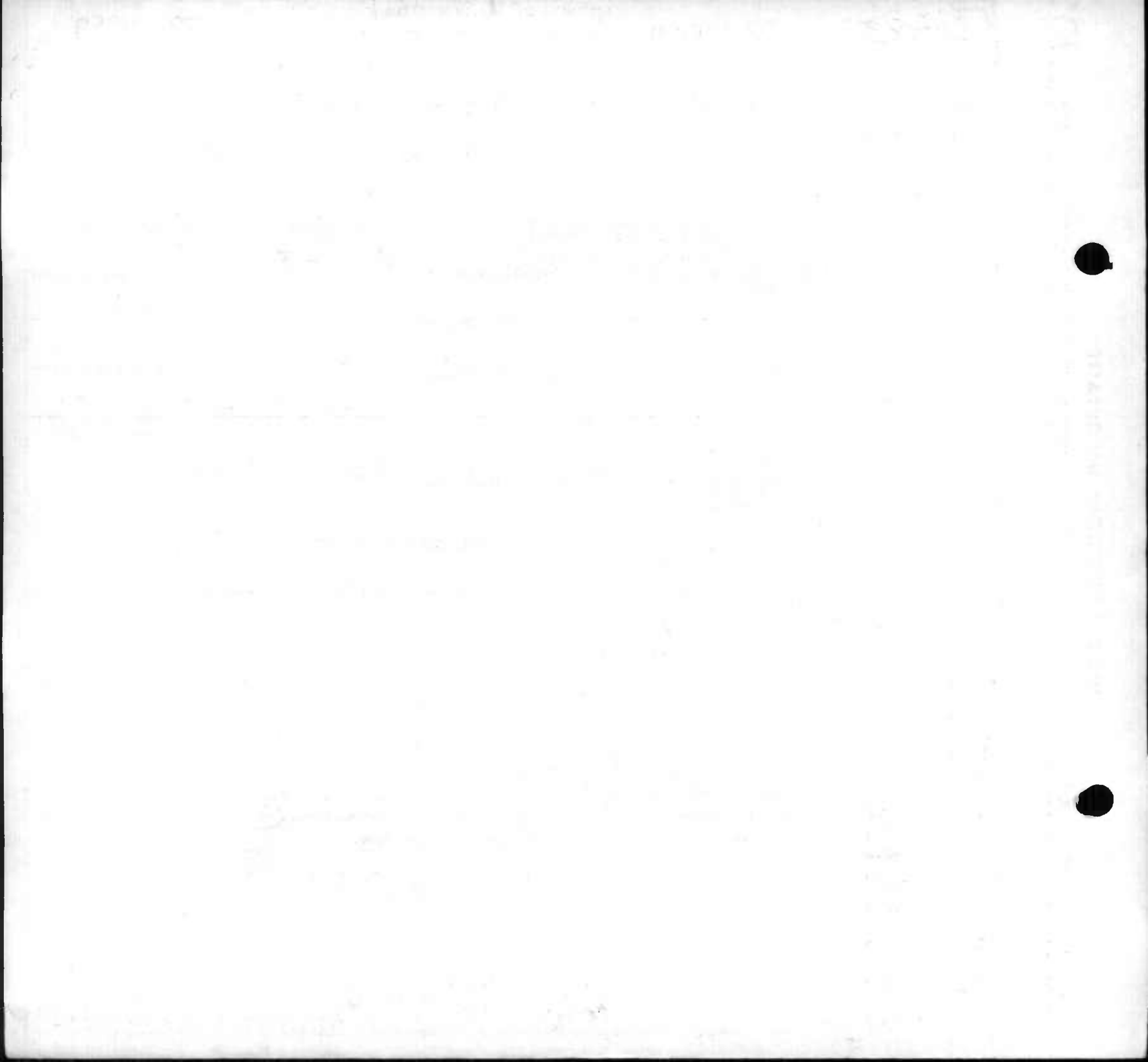
M-200		72 09088		BALTIMORE CITY HEALTH DEPARTMENT		72 09088	
CERTIFICATE OF DEATH				REG. NO.			
1. NAME OF DECEASED (Type or Print) <b>MACK, ALICE MARIE</b>				2. DATE AND HOUR OF DEATH <b>9/21/1972 4:25 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNIVERSITY OF MARYLAND 8 HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>1403</b>			
5. SEX <b>FEMALE</b>		6. RACE <b>BLACK</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/23/33</b>	
9. AGE (In years last birthday) <b>39</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Amos Jackson</b>				14. MOTHER'S MAIDEN NAME <b>Ella M. Young</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Geo. Mack</b>		ADDRESS <b>SAME</b>	
18. <b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) <b>CAQUEXIA</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>KRUKENBERG'S TUMOR TERMINAL STAGE</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>9/20/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>9/20 1972</b> to <b>9/21 1972</b> that (I) (we) last saw the deceased alive on <b>9/20 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>She Florence</b>				23B. DATE SIGNED <b>9/</b>		23C. PHYSICIAN'S NAME (Type) <b>FLORENTIN HERIBERTO</b>	
23D. ADDRESS <b>UNIVERSITY HOSPITAL</b>				23E. DATE REC'D BY HEALTH DEPT. <b>SEP 22 1972</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>				24B. DATE <b>9-25-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>BALTO. CEM.</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTO., MD.</b>				25A. FUNERAL DIRECTOR <b>Kelson F.H.</b>			
25B. NAME OF REGISTRAR <b>Dwight H. Hinton</b>				25C. ADDRESS <b>1348 Calhoun St.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

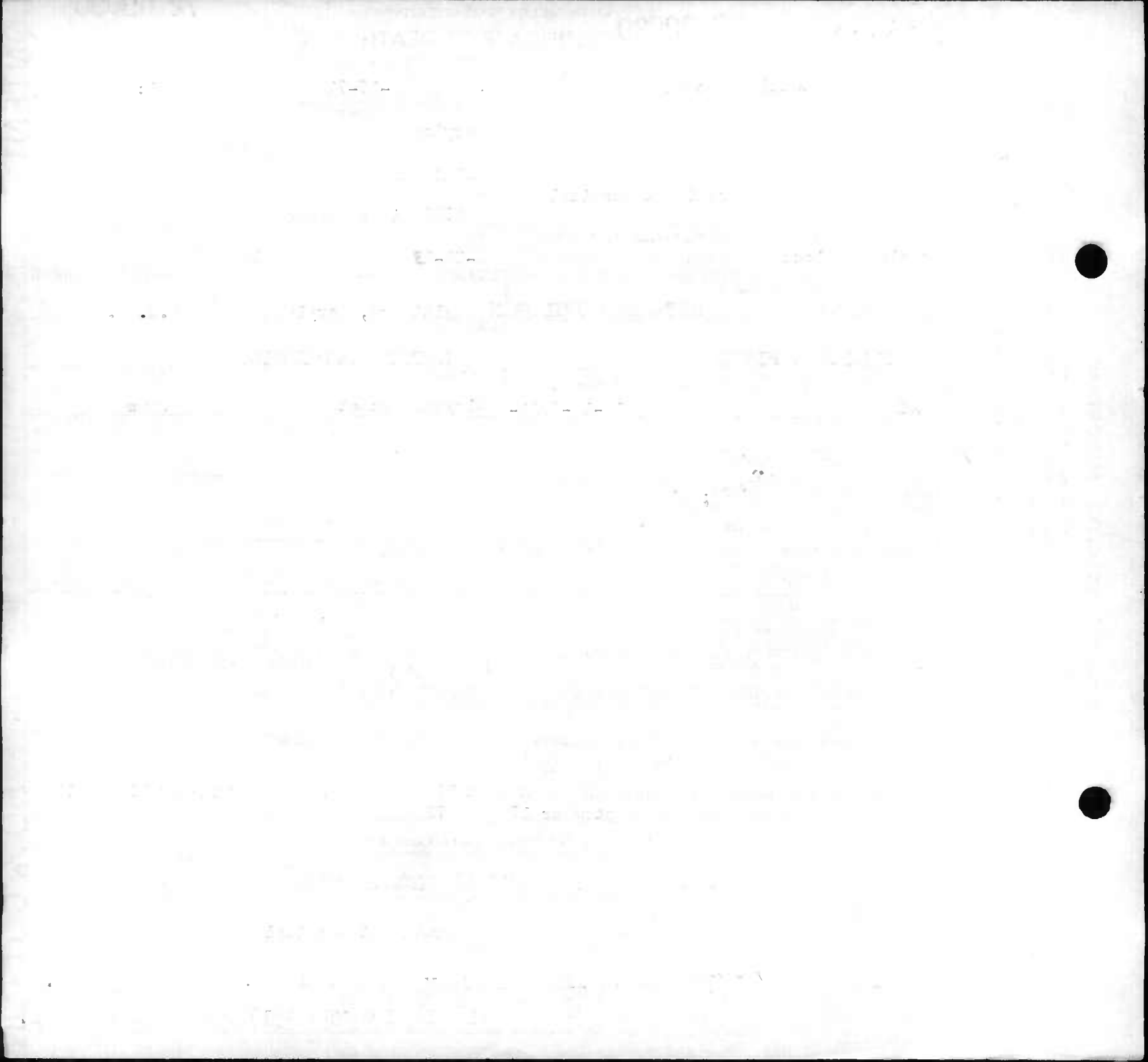
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 09089</b>	
K-563 72 09089				STATE OF MARYLAND-DEMD	
BIRTH NO.				DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Clarence Kinard</b>				2. DATE AND HOUR OF DEATH <b>9/19/72 12:10 A M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>8 Maryland General Hospital</b>				A. STATE <b>Maryland</b> B. COUNTY <b>1402</b>	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>1610 Druid Hill Ave.</b>	
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/12/29</b>	9. AGE (In years last birthday) <b>43</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Edward Kinard</b>			14. MOTHER'S MAIDEN NAME <b>Lula Crenshaw</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Lula Kinard 511 Bloom St.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Respiratory Failure</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Acute Pneumonic Process</b>			(B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>July 18, 1972</b> to <b>July 19, 1972</b> that (I) (we) last saw the deceased alive on <b>July 19, 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>William R. Davidson, M.D.</b>				23B. DATE SIGNED <b>9/19/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>William R. Davidson, M.D.</b>				23D. ADDRESS <b>Maryland General Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-22-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>mt. Auburn</b>	
24D. LOCATION <b>Balto., Md.</b>		24E. CITY, TOWN, OR COUNTY <b>Baltimore</b>		24F. STATE <b>Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 22 1972</b>		25B. NAME OF REGISTRAR <b>Andrew Whitson</b>		25C. FUNERAL DIRECTOR <b>Kelson F.H. 1348 Calhoun St</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. <span style="float: right;">72 09090</span>	
B-230 72 09090				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
Lettie Becoat		9-17-72 1:03 P.M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
FULL NAME OF HOSPITAL OR INSTITUTION		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)		5. SEX	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Maryland		Female	
39 Provident Hospital		B. COUNTY Baltimore		6. RACE Black	
		C. CITY OR TOWN Baltimore		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
		E. STREET AND NUMBER 2743 Riggs Avenue		8. DATE OF BIRTH 8-22-23	
				9. AGE (in years last birthday) 49	
				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COUNSELER	
				11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM A PITTS		14. MOTHER'S MAIDEN NAME LETTIE WASHINGTON		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO	
				16. SOCIAL SECURITY NO. 214-18-5051-	
				17. INFORMANT Clayton Becoat	
				ADDRESS Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Uremia		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chronic RENAL Failure			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Hypertensive and arteriosclerotic heart disease					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location)	
21C. WHERE DID INJURY OCCUR?		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from August 27 1972 to September 17 1972 that (I) (we) last saw the deceased alive on September 17 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE MARCO B. GALICIA, MD	
23B. DATE SIGNED 9/17/72		23C. PHYSICIAN'S NAME (Type) MARCO B. GALICIA, MD		23D. ADDRESS Provident Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/21/72		24C. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY	
24D. LOCATION (City, town, or county) (State) BALTIMORE MD.		25A. DATE REC'D BY HEALTH DEPT. SEP 22 1972		25B. NAME OF REGISTRAR LUDWIG H. HORTON	
25C. FUNERAL DIRECTOR LEWIS T GYNN		25D. ADDRESS 4517 PARK HEIGHTS AVE.			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 72 09091	
BIRTH NO. 72 09091		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Brengle, Earl		2. DATE AND HOUR OF DEATH September 22, 1972 6:30 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2854			
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Mercy Hospital 301 St. Paul St. 21202		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1736 Dartford Ave.					
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-01-04	9. AGE (In years last birthday) 67	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Harry Brengle		14. MOTHER'S MAIDEN NAME Mamie			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213 15 1440		17. INFORMANT Mrs Earl H. Brengle 4730 Dartford Ave 21229	
18. CAUSE OF DEATH 410.9! DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). INTERMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: DUE TO, OR AS A CONSEQUENCE OF: DUE TO, OR AS A CONSEQUENCE OF: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept 22 1972 to Sept 22 1972, that (I) (we) last saw the deceased alive on Sept 22 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Terry P. Detrich M.D.				23B. DATE SIGNED Sept 22, 1972	
23C. PHYSICIAN'S NAME (Type) Terry P. Detrich M.D.				23D. ADDRESS Witzke 1630 Edmondson Ave. Catonsville Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Sept 25, 1972		24C. NAME OF CEMETERY OR CREMATORY Druid Ridge	
24D. LOCATION Pikesville, Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 25 1972			
25B. NAME OF REGISTRAR Sidney Johnson		25C. FUNERAL DIRECTOR Witzke 1630 Edmondson Ave. Catonsville Md.			

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10-00-01

When 24-02-01

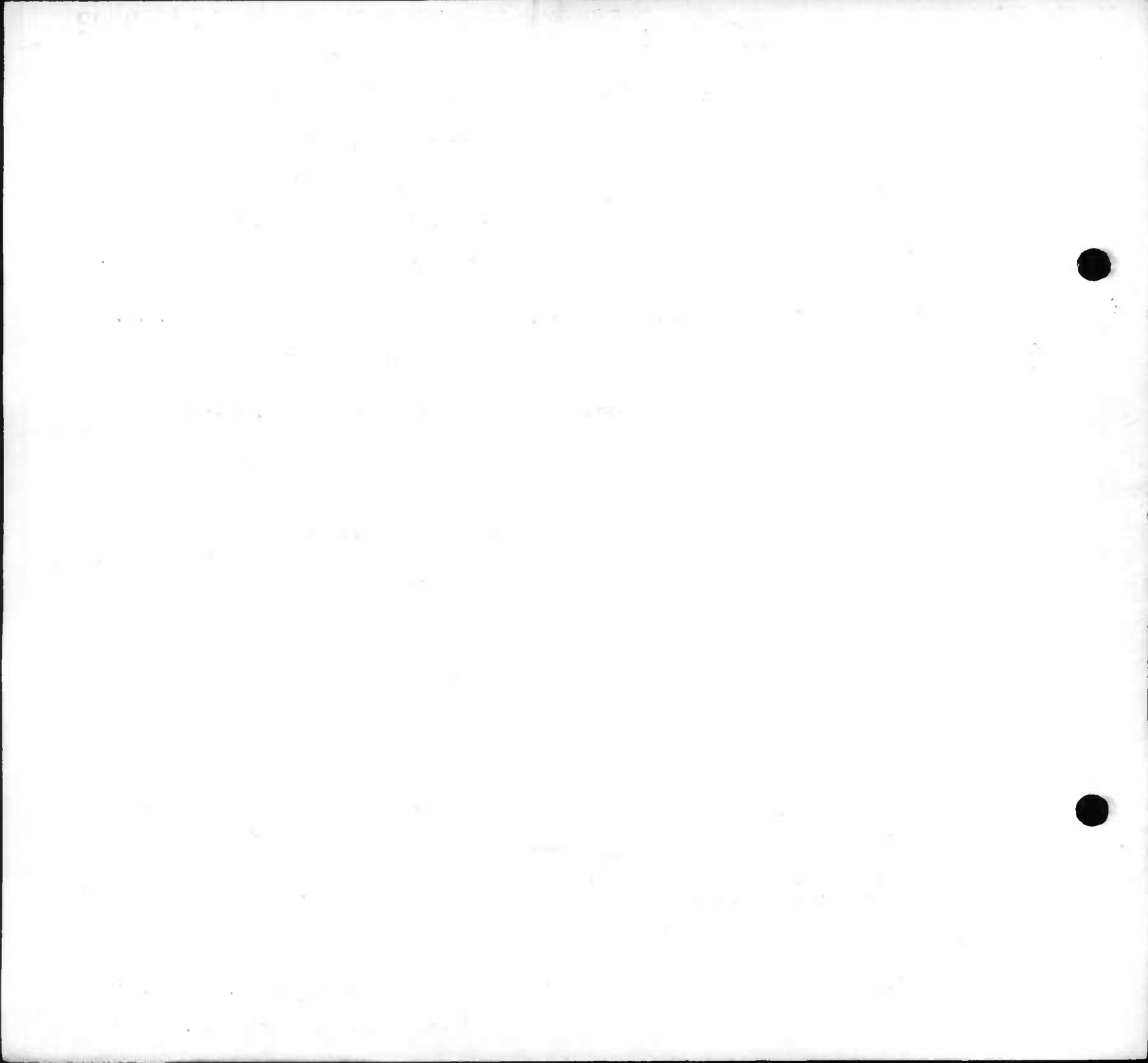
24-02-01



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09092		72 09092	
CERTIFICATE OF DEATH				STATE OF MARYLAND-DHMH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>LOUIS PFEIL LENZ</b>				2. DATE AND HOUR OF DEATH <b>9-21-72 3:10 PM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNIV. MD. HOSP. - BALTO.</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>Q-A</b> C. CITY OR TOWN <b>STEVENSVILLE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>NICKOLS Manor Drive</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-10-13</b>		9. AGE (In years last birthday) <b>59</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Captain</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Balto. Fire Dep't.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>George A Lenz</b>				14. MOTHER'S MAIDEN NAME <b>Agnes Helwig</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT ADDRESS <b>Mrs Louis Lenz Manor Dr. Stevensville Md</b>			
18. <b>153.8 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>RESP. INSUFFICIENCY</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>PULM. EMBOLUS</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>CA COLON</b> (C) <b>CA COLON</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 DAY</b> <b>3 MONS</b> <b>2X</b>			
				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>9-12-72</b> to <b>9-21-72</b> 19____ that (I) (we) last saw the deceased alive on <b>9-21-72</b> 19____ and that in (my) <del>my</del> opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <b>[Signature]</b>				23B. DATE SIGNED <b>9-21-72</b>		23C. PHYSICIAN'S NAME (Type) <b>[Signature]</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>Sept 25 '72</b>		24C. NAME of CEMETERY or CREMATORY <b>Loudon Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Frederick Rd. Balto. Md</b>				25A. DATE REC'D BY HEALTH DEPT. <b>SEP 25 1972</b>			
25B. NAME OF REGULAR FUNERAL DIRECTOR <b>Witzke</b>				25C. ADDRESS <b>1630 Edmondson Ave. Catonsville</b>			



S-624 72 09093

STATE OF MARYLAND-DEPT.  
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 09093

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>Elfriede W. ELFRIDA SORGELER</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> <b>September 21, 1972</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>113 S. Rock Glen Road</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>September 21, 1972 1:05 P.M.</b>	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2854</b>			
6. SEX <b>Female</b>	7. RACE <b>White</b>	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>Nov. 22, 1915</b>		10. AGE (In years last birthday) <b>56</b>	
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. <b>None</b>	
18. INFORMANT <b>Karl F. W. Sorgeler 113 Rock Glen Rd Balto.</b>		ADDRESS	
19. <b>E953X</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Hanging</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>113 S. Rock Glen Road</b>		22F. HOW DID INJURY OCCUR? <b>Hanged herself</b>	
22D. TIME OF INJURY (APPROX.) <b>9-21-72 ?? m.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Marvin S. Platt, M.D.</b>		DATE SIGNED <b>9/22/72</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		24B. DATE <b>Sept. 23, 1972</b>	
24C. NAME of CEMETERY or CREMATORY <b>Loudon Park</b>		24D. LOCATION (City, town, or county) (State) <b>Frederick Rd. Balto. Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 25 1972</b>		25B. NAME OF REGISTRAR <b>A. J. [Signature]</b>	
25C. FUNERAL DIRECTOR <b>Witzke</b>		ADDRESS <b>1630 Edmondson Ave. Catonsville</b>	

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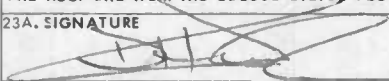
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99. [Illegible text]

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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
72 09094 CERTIFICATE OF DEATH										
REG. NO. 72 09094 STATE OF MARYLAND										
BIRTH NO. <b>B-420</b>					72 09094					
1. NAME OF DECEASED (Type or Print) <b>BLISS, DOROTHY TICKNER</b>					2. DATE AND HOUR OF DEATH <b>SEPTEMBER 20, 1972 1.00 P.M.</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>ST. AGNES HOSPITAL WILKENS &amp; CATON AVENUE BALTIMORE, MARYLAND 21229</b>					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTO</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>1 N. ROLLING ROAD, 21228</b>					
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-05-10</b>	9. AGE (In years last birthday) <b>61</b>	10. Under 1 Yr. Months: Oays:	11. Under 24 Hrs. Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>HOMEMAKING</b>			11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>CHARLES TICKNER</b>					14. MOTHER'S MAIDEN NAME <b>DEC'D CATHERINE (MILLER) DEC'D</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>BALTIMORE, MD. ST. AGNES HOSPITAL, WILKENS &amp; CATON AVE.</b>					
18. <b>431.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Probable Cerebral hemorrhage</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Subdural hematoma</b>					CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>20 min</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>3 weeks</b> (C) _____					
MEDICAL CERTIFICATION										
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>II</b>										
19A. DATE OF OPERATION <b>0</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <b>AUGUST 12 1972</b> to <b>SEPTEMBER 20 1972</b> , that (I) (we) last saw the deceased alive on <b>SEPTEMBER 20 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE 					23B. DATE SIGNED <b>9/20/72</b>			23C. PHYSICIAN'S NAME (Type) <b>Daniel Huerta, M.D.</b>		
23D. ADDRESS <b>SAH</b>					23E. DATE REC'D BY HEALTH DEPT. <b>SEP 25 1972</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>9/23/72</b>			24C. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Cemetery</b>			24D. LOCATION (City, town, or county) (State) <b>Dorsey, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 25 1972</b>					25B. NAME OF REGISTRAR <b>Sidney H. Hinton</b>			25C. FUNERAL DIRECTOR <b>Witzke, 1630 Edmondson Avenue 21228</b>		

1-00 9

SEPTEMBER 20, 1932

ELISSA, WORTHY TICKET

MARYLAND

1. LINDONE

1. W. ROLLING ROAD,

ST. AGNES HOSPITAL  
1100 S. CATON AVE.  
BALTIMORE, MARYLAND 21225

11-02-10

FEMALE WHITE

MARYLAND

HOUSEWIFE

HOUSEWIFE

DECIO CATHERINE (WILLER)

CHARLES TICKET

ST. AGNES HOSPITAL  
1100 S. CATON AVE.  
BALTIMORE, MD.

SEPTEMBER 20 - 21

SEPTEMBER 20 TO  
AUGUST 12

1-00 9

X

ST. AGNES HOSPITAL

ST. AGNES HOSPITAL

ST. AGNES HOSPITAL

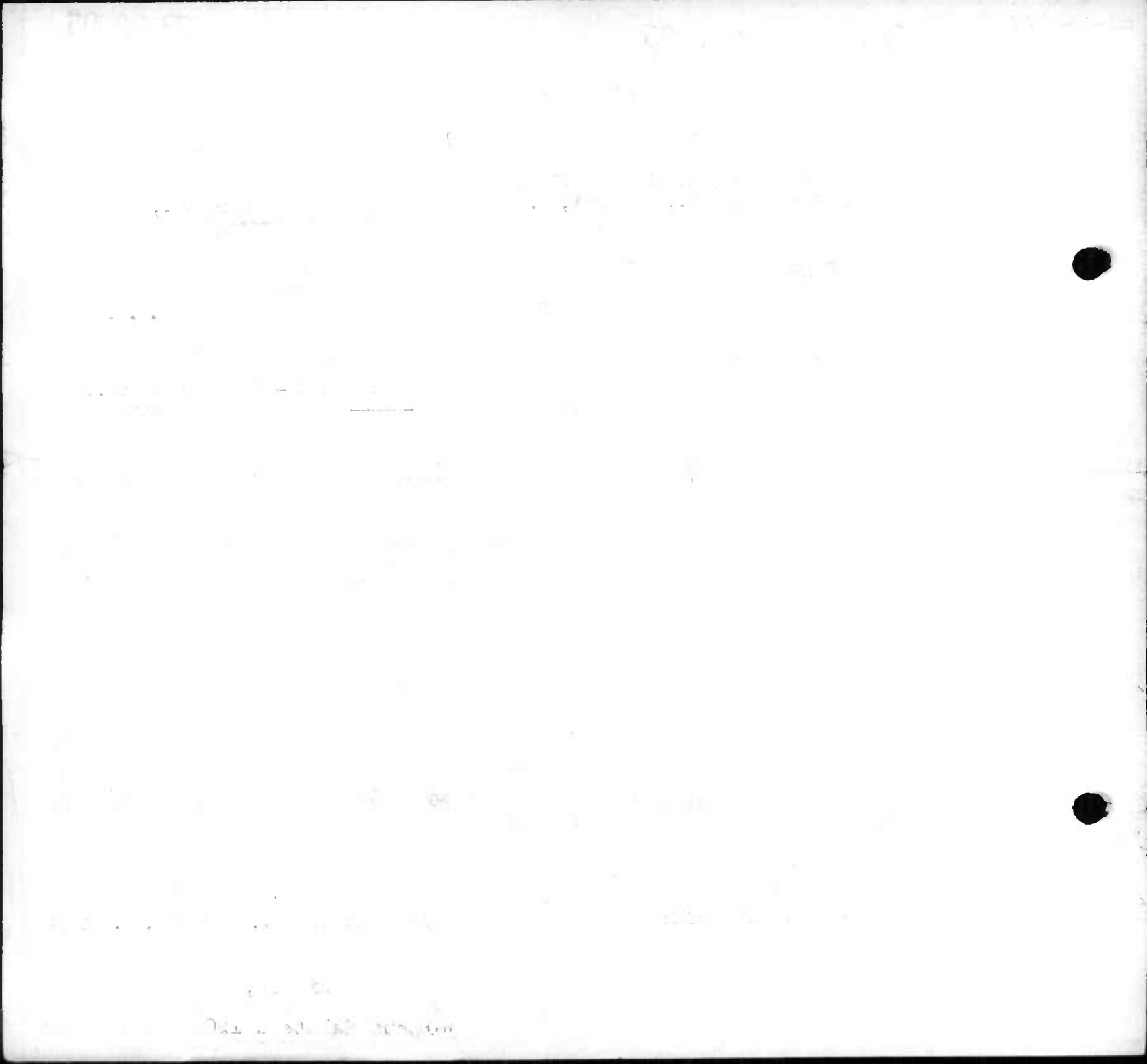
ST. AGNES HOSPITAL

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		72 09095		REG. NO.		72 09095	
1. NAME OF DECEASED (Type or Print)		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		5. CITY OR TOWN		D. INSIDE CITY LIMITS?	
DAISY BELLE BOND		Baltimore City Hospitals 21224 4940 Eastern Ave., Baltimore, Md.		MARYLAND - 2612		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country)	
Female				11-30-13		69		MARYLAND	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Housewife				U.S.A.		LEE WATSON		UNKNOWN LILLIE WEAVER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		UNKNOWN		Records: BCH-4940 Eastern Ave., NONE - 21224		<p>18. 599.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>		<p>(A) IMMEDIATE CAUSE <u>CONV. SEPTICEMIA</u></p> <p>DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) <u>CEREBROVASCULAR ACCIDENT</u></p> <p>DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) <u>CHRONIC HTN -</u></p>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from		23A. SIGNATURE		23B. DATE SIGNED					
5-26-65 to 9-22-72		Philip Smith		9-22-72					
that (I) (we) last saw the deceased alive on		23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS					
9-22-72		Philip Smith		4940 Eastern Ave., Baltimore, Md. 21224					
and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
		Burial		9/26/72		Mt. Auburn Cemetery		Baltimore, Md	
25A. DATE OF DEATH		25B. NAME OF FUNERAL HOME		25C. FUNERAL DIRECTOR		25D. ADDRESS			
SEP 25 1972		Adolphus Halstead		1206 W North Ave					

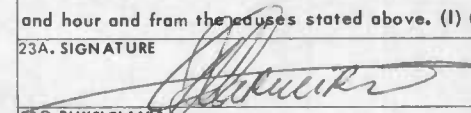






# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 09096</b>
E-236 72 09096 CERTIFICATE OF DEATH				STATE OF MARYLAND-DHMH
BIRTH NO. <b>72 09096</b>		2. DATE AND HOUR OF DEATH <b>SEPT. 22nd, 1972 11:55 P.M.</b>		
1. NAME OF DECEASED (Type or Print) <b>HARVEY EASTERLING</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTIMORE</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>44 Union Mem Hospital</b>		C. CITY OR TOWN <b>BALTO.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <b>MALE</b> 6. RACE <b>BLACK</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>03/20/1943</b> 9. AGE (In years last birthday) <b>29</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <b>S. CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Harry</b>		14. MOTHER'S MAIDEN NAME <b>Hattie</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-40-9167</b>		17. INFORMANT <b>Chart</b>
18. <b>553.8 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>SEPTIC SHOCK</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>GANGRENE OF SMALL BOWEL</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>INTERNAL HERNIA</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>CHRONIC ALCOHOLISM</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <b>09/22/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>SMALL BOWEL GANGRENE</b>		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>SEPT. 22, 1972</b> to <b>Sept. 22, 1972</b> , that (I) (we) last saw the deceased alive on <b>Sept 22, 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE 		23B. DATE SIGNED <b>Sept. 22, 1972</b>		23C. PHYSICIAN'S NAME (Type) <b>RONALDO S. CARNEIRO</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/27/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt Auburn Cemetry</b>
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 25 1972</b>		25B. NAME OF REGISTRAR <b>Anthony Indurona</b>		25C. FUNERAL DIRECTOR <b>Adolphus Halstead</b>
25D. ADDRESS <b>1206 W North Ave</b>				

75-10000

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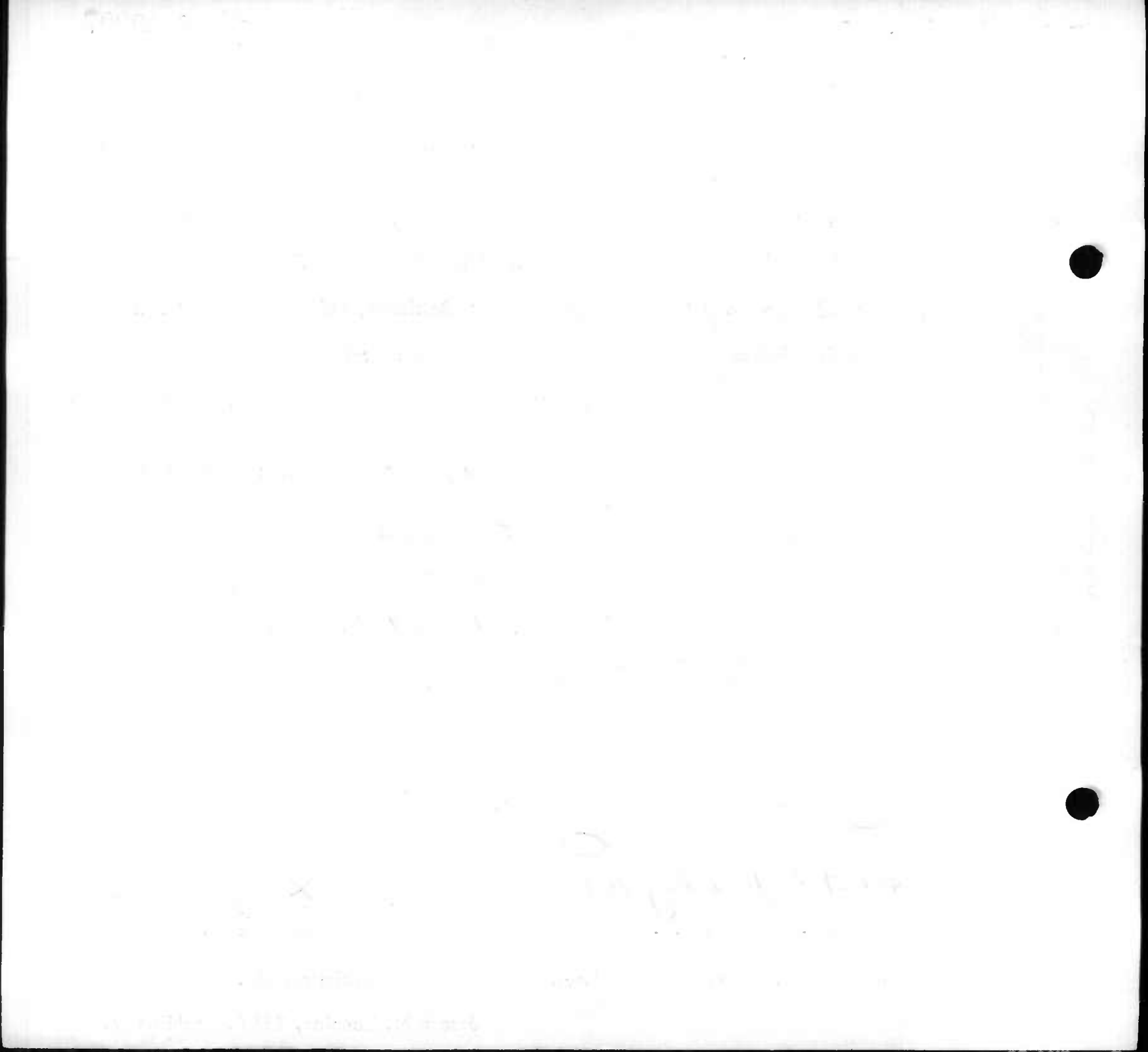
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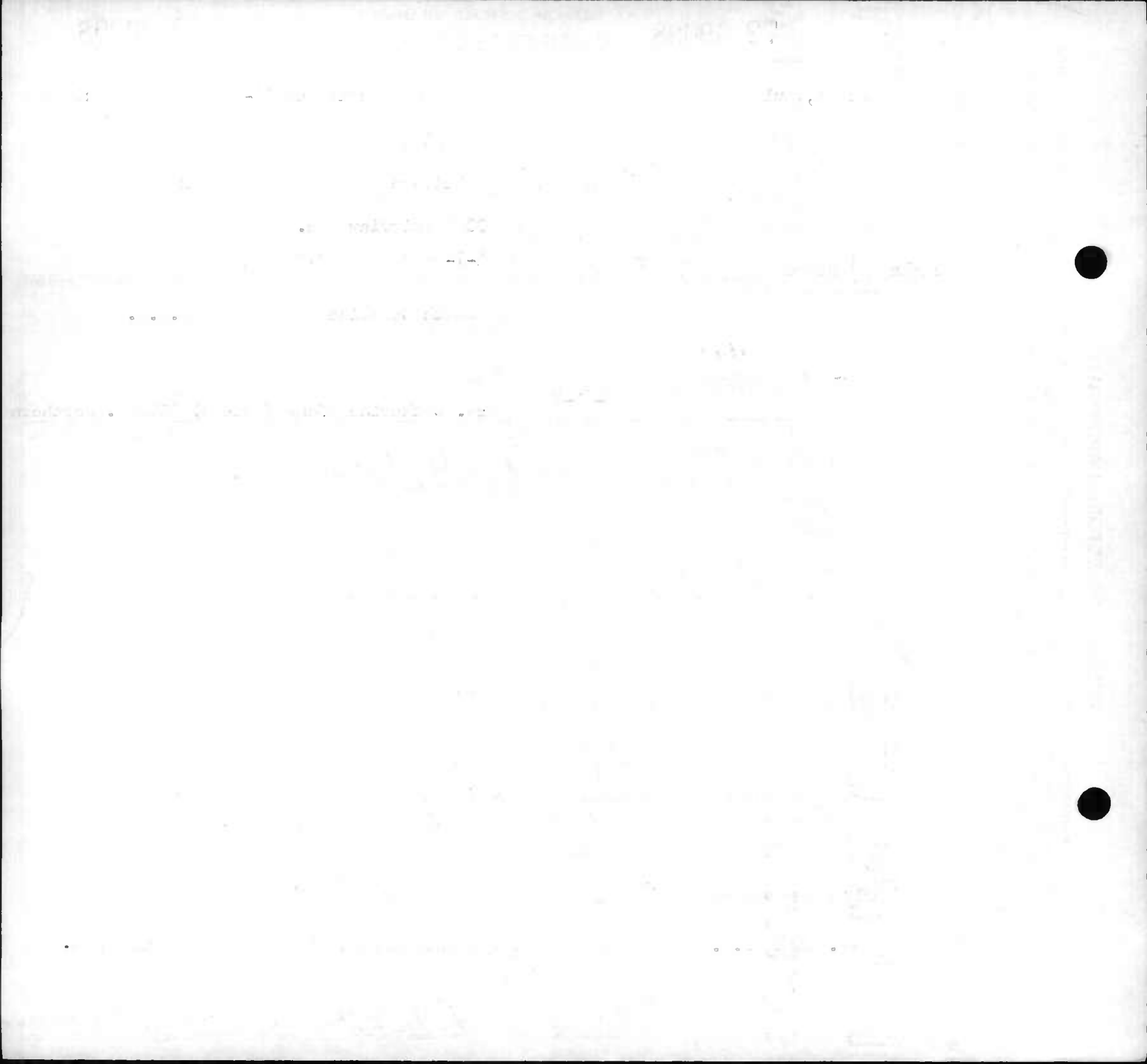
BALTIMORE CITY HEALTH DEPARTMENT				72 09097		REG. NO. 72 09097	
BIRTH NO. 72 09097				STATE OF MARYLAND - DEATH			
1. NAME OF DECEASED (Type or Print) Antionette Rowllins				2. DATE AND HOUR OF DEATH 9/23/72 6:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 601 South Newkirk Street 21224			
5. SEX Female	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7/12/35	% AGE (in years last birthday) 37	If Under 1 Yr. Months	If Under 1 Yr. Days	If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sorter path step Retired				11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis DeFelice				14. MOTHER'S MAIDEN NAME Anna Prato			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 219-30-0723		17. INFORMANT 4940 Eastern Avenue Baltimore, Maryland 21224 BCH: RECORDS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 01966 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Mitral stenosis (J.H.H.) 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from 16 March 1972 to 23 Sept 1972 that (I) (we) last saw the deceased alive on 23 Sept 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE Hubert G. Markley M.D. 23B. DATE SIGNED 9/23/72 23C. PHYSICIAN'S NAME (Type) Hubert G. Markley, M.D. 23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 9/26/72 24C. NAME of CEMETERY or CREMATORY Sacred Heart 24D. LOCATION (City, town, or county) (State) Baltimore, Md. 25A. DATE REC'D BY HEALTH DEPT. SEP 25 1972 25B. NAME OF REGISTRAR Joseph N. Zannino 25C. FUNERAL DIRECTOR Joseph N. Zannino, 263 S. Conkling St.							



# FUNERAL DIRECTOR: IMPORTANT

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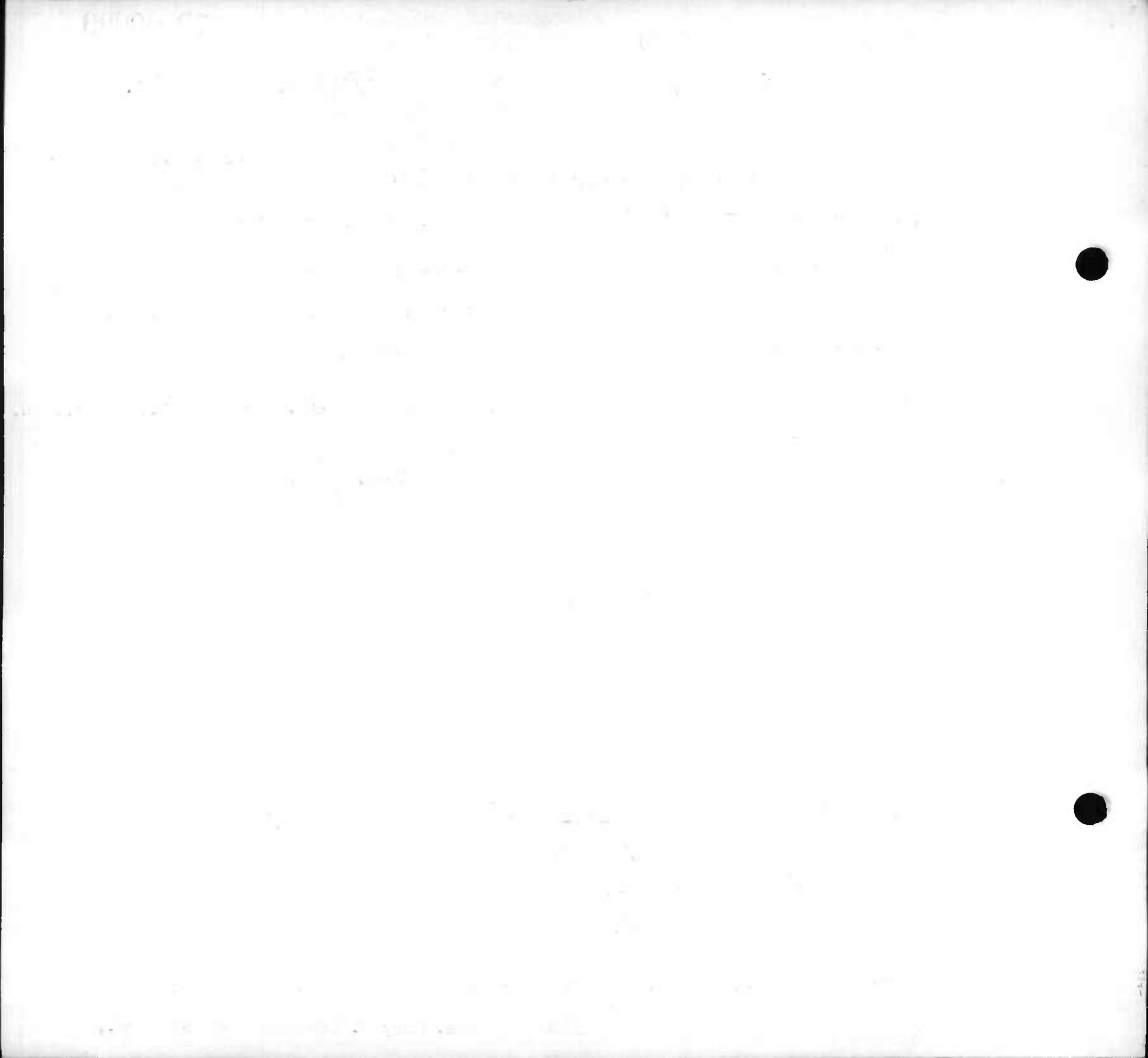
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09098	
M-200 72 09098				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
MacKey, Lula		September 22-1972 12:36 p.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 39		A. STATE Maryland B. COUNTY 1537			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital, Inc. 2600 Liberty Heights Ave. BALTIMORE, Md 21215		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female		6. RACE Negro		E. STREET AND NUMBER 3301 Fairview Ave.	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-7-00		9. AGE (In years last birthday) 72	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-01-7850		17. INFORMANT Mrs. Catherine Adams (Friend) 1100 W. Northern	
18. 450X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Probable Pulmonary Embolus</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>Chronic pancreatitis</i>					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg. etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9 A.M. 9/22 19 72 to 12:36 9/22 19 72 that (I) (we) last saw the deceased alive on 9/22 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Marion A. Allen, M.D.</i>				23B. DATE SIGNED September 22, 1972	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS PROVIDENT HOSPITAL 2600 LIBERTY HEIGHT AVE.	
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 9-26-72		24C. NAME OF CEMETERY or CREMATORY ARBUTUS MEM PARK	
24D. LOCATION BALTO, COUNTY		24E. NAME OF REGISTRAR SEP 25 1972			
24F. NAME OF REGISTRAR SEP 25 1972		24G. NAME OF REGISTRAR SEP 25 1972		24H. NAME OF REGISTRAR SEP 25 1972	
24I. NAME OF REGISTRAR SEP 25 1972		24J. NAME OF REGISTRAR SEP 25 1972		24K. NAME OF REGISTRAR SEP 25 1972	
24L. NAME OF REGISTRAR SEP 25 1972		24M. NAME OF REGISTRAR SEP 25 1972		24N. NAME OF REGISTRAR SEP 25 1972	
24O. NAME OF REGISTRAR SEP 25 1972		24P. NAME OF REGISTRAR SEP 25 1972		24Q. NAME OF REGISTRAR SEP 25 1972	
24R. NAME OF REGISTRAR SEP 25 1972		24S. NAME OF REGISTRAR SEP 25 1972		24T. NAME OF REGISTRAR SEP 25 1972	
24U. NAME OF REGISTRAR SEP 25 1972		24V. NAME OF REGISTRAR SEP 25 1972		24W. NAME OF REGISTRAR SEP 25 1972	
24X. NAME OF REGISTRAR SEP 25 1972		24Y. NAME OF REGISTRAR SEP 25 1972		24Z. NAME OF REGISTRAR SEP 25 1972	
24AA. NAME OF REGISTRAR SEP 25 1972		24AB. NAME OF REGISTRAR SEP 25 1972		24AC. NAME OF REGISTRAR SEP 25 1972	
24AD. NAME OF REGISTRAR SEP 25 1972		24AE. NAME OF REGISTRAR SEP 25 1972		24AF. NAME OF REGISTRAR SEP 25 1972	
24AG. NAME OF REGISTRAR SEP 25 1972		24AH. NAME OF REGISTRAR SEP 25 1972		24AI. NAME OF REGISTRAR SEP 25 1972	
24AJ. NAME OF REGISTRAR SEP 25 1972		24AK. NAME OF REGISTRAR SEP 25 1972		24AL. NAME OF REGISTRAR SEP 25 1972	
24AM. NAME OF REGISTRAR SEP 25 1972		24AN. NAME OF REGISTRAR SEP 25 1972		24AO. NAME OF REGISTRAR SEP 25 1972	
24AP. NAME OF REGISTRAR SEP 25 1972		24AQ. NAME OF REGISTRAR SEP 25 1972		24AR. NAME OF REGISTRAR SEP 25 1972	
24AS. NAME OF REGISTRAR SEP 25 1972		24AT. NAME OF REGISTRAR SEP 25 1972		24AU. NAME OF REGISTRAR SEP 25 1972	
24AV. NAME OF REGISTRAR SEP 25 1972		24AW. NAME OF REGISTRAR SEP 25 1972		24AX. NAME OF REGISTRAR SEP 25 1972	
24AY. NAME OF REGISTRAR SEP 25 1972		24AZ. NAME OF REGISTRAR SEP 25 1972		24BA. NAME OF REGISTRAR SEP 25 1972	
24BA. NAME OF REGISTRAR SEP 25 1972		24BB. NAME OF REGISTRAR SEP 25 1972		24BC. NAME OF REGISTRAR SEP 25 1972	
24BB. NAME OF REGISTRAR SEP 25 1972		24BD. NAME OF REGISTRAR SEP 25 1972		24BD. NAME OF REGISTRAR SEP 25 1972	
24BD. NAME OF REGISTRAR SEP 25 1972		24BE. NAME OF REGISTRAR SEP 25 1972		24BE. NAME OF REGISTRAR SEP 25 1972	
24BE. NAME OF REGISTRAR SEP 25 1972		24BF. NAME OF REGISTRAR SEP 25 1972		24BF. NAME OF REGISTRAR SEP 25 1972	
24BF. NAME OF REGISTRAR SEP 25 1972		24BG. NAME OF REGISTRAR SEP 25 1972		24BG. NAME OF REGISTRAR SEP 25 1972	
24BG. NAME OF REGISTRAR SEP 25 1972		24BH. NAME OF REGISTRAR SEP 25 1972		24BH. NAME OF REGISTRAR SEP 25 1972	
24BH. NAME OF REGISTRAR SEP 25 1972		24BI. NAME OF REGISTRAR SEP 25 1972		24BI. NAME OF REGISTRAR SEP 25 1972	
24BI. NAME OF REGISTRAR SEP 25 1972		24BJ. NAME OF REGISTRAR SEP 25 1972		24BJ. NAME OF REGISTRAR SEP 25 1972	
24BJ. NAME OF REGISTRAR SEP 25 1972		24BK. NAME OF REGISTRAR SEP 25 1972		24BK. NAME OF REGISTRAR SEP 25 1972	
24BK. NAME OF REGISTRAR SEP 25 1972		24BL. NAME OF REGISTRAR SEP 25 1972		24BL. NAME OF REGISTRAR SEP 25 1972	
24BL. NAME OF REGISTRAR SEP 25 1972		24BM. NAME OF REGISTRAR SEP 25 1972		24BM. NAME OF REGISTRAR SEP 25 1972	
24BM. NAME OF REGISTRAR SEP 25 1972		24BN. NAME OF REGISTRAR SEP 25 1972		24BN. NAME OF REGISTRAR SEP 25 1972	
24BN. NAME OF REGISTRAR SEP 25 1972		24BO. NAME OF REGISTRAR SEP 25 1972		24BO. NAME OF REGISTRAR SEP 25 1972	
24BO. NAME OF REGISTRAR SEP 25 1972		24BP. NAME OF REGISTRAR SEP 25 1972		24BP. NAME OF REGISTRAR SEP 25 1972	
24BP. NAME OF REGISTRAR SEP 25 1972		24BQ. NAME OF REGISTRAR SEP 25 1972		24BQ. NAME OF REGISTRAR SEP 25 1972	
24BQ. NAME OF REGISTRAR SEP 25 1972		24BR. NAME OF REGISTRAR SEP 25 1972		24BR. NAME OF REGISTRAR SEP 25 1972	
24BR. NAME OF REGISTRAR SEP 25 1972		24BS. NAME OF REGISTRAR SEP 25 1972		24BS. NAME OF REGISTRAR SEP 25 1972	
24BS. NAME OF REGISTRAR SEP 25 1972		24BT. NAME OF REGISTRAR SEP 25 1972		24BT. NAME OF REGISTRAR SEP 25 1972	
24BT. NAME OF REGISTRAR SEP 25 1972		24BU. NAME OF REGISTRAR SEP 25 1972		24BU. NAME OF REGISTRAR SEP 25 1972	
24BU. NAME OF REGISTRAR SEP 25 1972		24BV. NAME OF REGISTRAR SEP 25 1972		24BV. NAME OF REGISTRAR SEP 25 1972	
24BV. NAME OF REGISTRAR SEP 25 1972		24BV. NAME OF REGISTRAR SEP 25 1972		24BV. NAME OF REGISTRAR SEP 25 1972	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09099		REG. NO. 72 09099	
BIRTH NO. 1-523				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH		STATE OF MARYLAND-DEME	
LINGTON, Lucille				9/15/72.		12.55 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE 8. COUNTY			
45 The Good Samaritan Hospital Baltimore-Maryland				Maryland C. CITY OR TOWN D. INSIDE CITY LIMITS? Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER				859. Mc Aleer Street			
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
F		Negro		04-24-21		9. AGE (In years lost birthday) 51	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
James Weston				Bertha Lee		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				Guy Cephas		204 W. Saratoga St., Balto., Md.	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				Squamous cell Carcinoma of larynx, metastatic to lungs			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				1 year			
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:				(D) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				19A. DATE OF OPERATION			
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 08-09 1972 to 09-15 1972 that (I) (we) last saw the deceased alive on 09-15-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
Jose Martinez, MD				9/15/72		The Good Samaritan Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial				9/19/72		Mt. Calvary Cemetery	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
SEP 25 1972				Mrs. Mary E. Law		802 Madison Ave.,	





A-416

72 09100

STATE OF MARYLAND  
BALTIMORE CITY HEALTH DEPARTMENT

72 09100

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

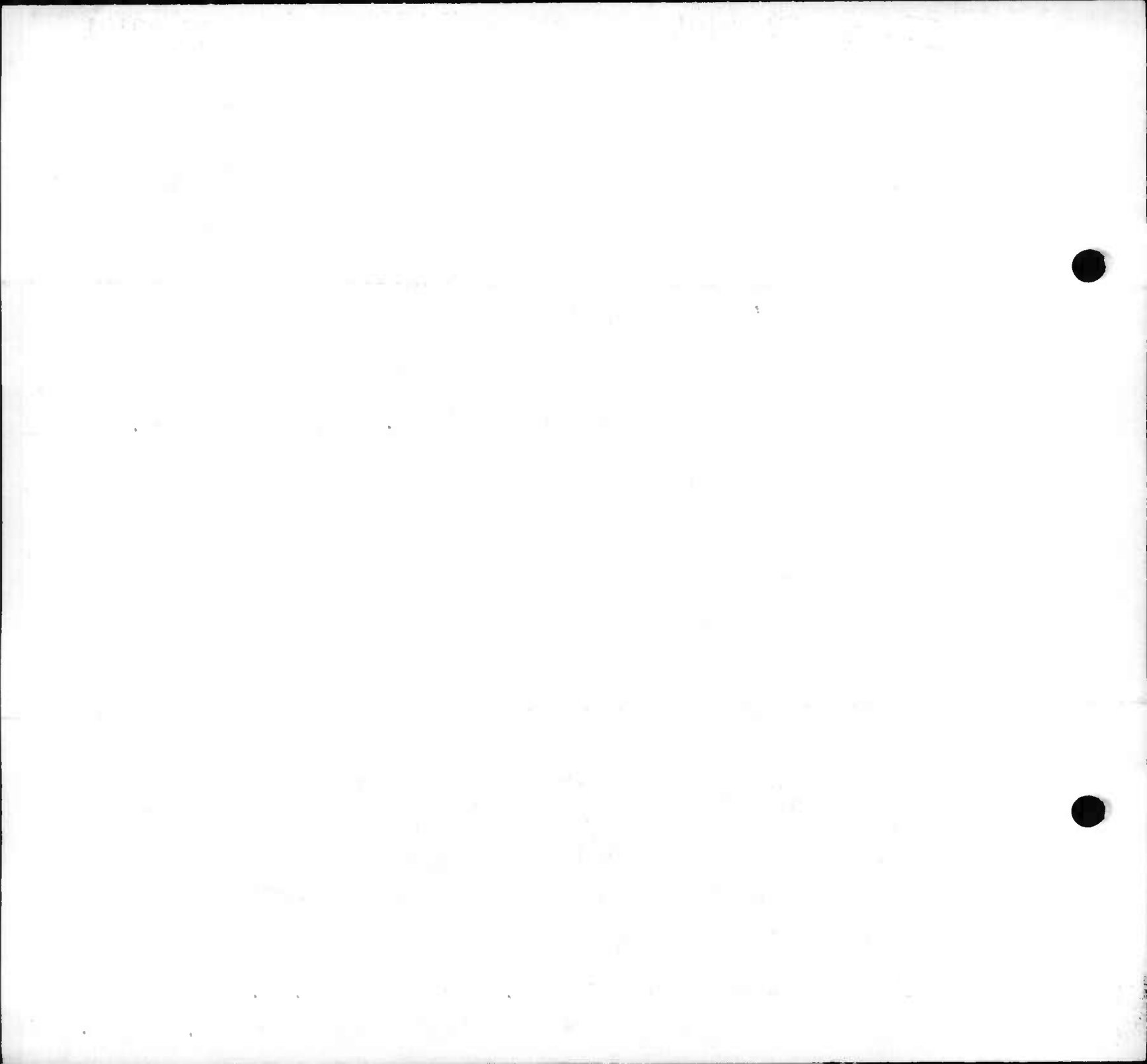
1. NAME OF DECEASED (Type or Print) <b>GEORGE W. ALBERSON</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> <b>9-21-72</b>		M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>813 St. Paul Street, Apt.3-A</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>September 21, 1972 10:20 A.M.</b>		
6. SEX <b>Male</b>		7. RACE <b>White</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. DATE OF BIRTH <b>6 APR. 1914</b>		10. AGE (In years lost birthday) <b>58</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>WILLIAM ALBERSON</b>		
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LIAISON OFFICER</b>		15. KIND OF BUSINESS OR INDUSTRY <b>DEPT. OF THE ARMY</b>		16. MOTHER'S MAIDEN NAME <b>LAURA SCHEITRUM</b>
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WWII</b>		18. SOCIAL SECURITY NO. <b>182-46-5863</b>		19. INFORMANT <b>Mrs. BLANCHE McLAUGHLIN, PENN ARGYL, PA.</b>
20. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
21. DATE OF OPERATION <b>2</b>		22. CONDITION FOR WHICH OPERATION WAS PERFORMED		23. AUTOPSY? (Yes or No) <b>Yes</b>
24. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		26. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
27. TIME (Month) (Day) (Year) (Hour) (Approx.)		28. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		29. HOW DID INJURY OCCUR?
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Marvin S. Platt</b> M.D. EXAMINER'S NAME (Type) <b>Marvin S. Platt, M.D.</b>  CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>September 21, 1972</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>REMOV/BUR.</b>		24B. DATE <b>22-25 Sept. 72</b>		24C. NAME OF CEMETERY or CREMATORY <b>St. John's Lutheran Cem.</b>
24D. LOCATION (City, town, or county) (State) <b>TAMAGUA, PA.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 25 1972</b>		
25B. NAME OF REGISTRAR <b>Arlene H. Wilson</b>		25C. FUNERAL DIRECTOR <b>St. John's Lutheran Home</b> <b>BALTO, MD.</b>		
25D. ADDRESS <b>FOR ZIEGLMANN FUN. HSE.</b> <b>TAMAGUA, PA.</b>				



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

I-356 72 09101		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		72 09101 STATE OF MARYLAND-DHME	
1. NAME OF DECEASED (Type or Print) <b>FLOY ITNYRE</b>		2. DATE AND HOUR OF DEATH <b>9-20-72 1030 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>UNIVERSITY</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>2634</b>		C. CITY OR TOWN <b>BALTO.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY</b>		E. STREET AND NUMBER <b>5025 WRIGHT AVE</b>			
5. SEX <b>F</b>	6. RACE <b>CAU</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/12/31</b>	9. AGE (In years last birthday) <b>41</b>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INSPECTOR</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>MD. CAP CO.</b>		11. BIRTHPLACE (State or foreign country) <b>MD</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>WILBUR BLEKENSTAFF</b>		14. MOTHER'S MAIDEN NAME <b>LENA GUNSTROM</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hubert R. Itnyre 5055 Wright Ave. 21205</b>	
18. <b>44-2X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF: <b>CEREBRAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF: <b>CEREBRAL ANEURYSM</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>9-14-72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>SUB-ARACHNOID HEMM.</b>		20A. AUTOPSY? (Yes or No) <b>—</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (If yes, specify) <b>N/A</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>N/A</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>N/A</b>	
21D. TIME OF INJURY (APPROX.) <b>N/A</b>		21E. INJURY OCCURRED While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>N/A</b>	
22. I certify that (1) (this hospital) attended the deceased from <b>9-10</b> 19 <b>72</b> to <b>9-20</b> 19 <b>72</b> that (1) (we) last saw the deceased alive on <b>9-20</b> 19 <b>72</b> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>David M. Cook</b>		23B. DATE SIGNED <b>9-20-72</b>			
23C. PHYSICIAN'S NAME (Type) <b>DAVID M. COOK</b>		23D. ADDRESS <b>UNIVERSITY HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-25-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 25 1972</b>		25B. NAME OF REGISTRAR <b>Lindsey Whitman</b>		25C. FUNERAL DIRECTOR <b>McGully Funeral Home 130 E. Fort Ave. 21230</b>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09102	
C-632 72 09102				STATE OF MARYLAND - DENVER	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>CREITZ, MARGARET</b>		2. DATE AND HOUR OF DEATH <b>9/20/72 10:30 A M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>The Johns Hopkins Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Pennsylvania</b> B. COUNTY <b>V35</b> C. CITY OR TOWN <b>Newton-Hamilton</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER		
5. SEX <b>Female</b>	6. RACE <b>Cauc.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/12/06</b> <del>10/19/07</del>	9. AGE (In years last birthday) <b>65</b> <del>64</del>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Home maker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Timothy Kennedy</b>		
14. MOTHER'S MAIDEN NAME <b>Kathleen McAndrew</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>N/A</b>			17. INFORMANT <b>CLARK FUNERAL HOME</b>		
18. ADDRESS <b>MT. Union Pa.</b>			19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.) <b>RESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF: <b>BRAIN TUMOR</b> DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>9/19/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO</b>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <b>9/19/72</b> 19 to <b>9/20/72</b> 19, that (I) <u>(we)</u> last saw the deceased alive on <b>9/20/72</b> 19 and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED <b>9/20/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>JUAN LOPEZ M.D.</b>				23D. ADDRESS <b>JHH on fute</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-24-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Riverview Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Huntingdon, Pennsylvania</b>		25A. NAME RECEIVED BY HEALTH DEPT. <b>SEP 25 1972</b>			
25B. NAME OF REGISTRAR <b>Bridgette</b>		25C. FUNERAL DIRECTOR <b>Wm. Cook-brooks</b>			
25D. ADDRESS <b>Towson Towson, Md. 21204</b>					

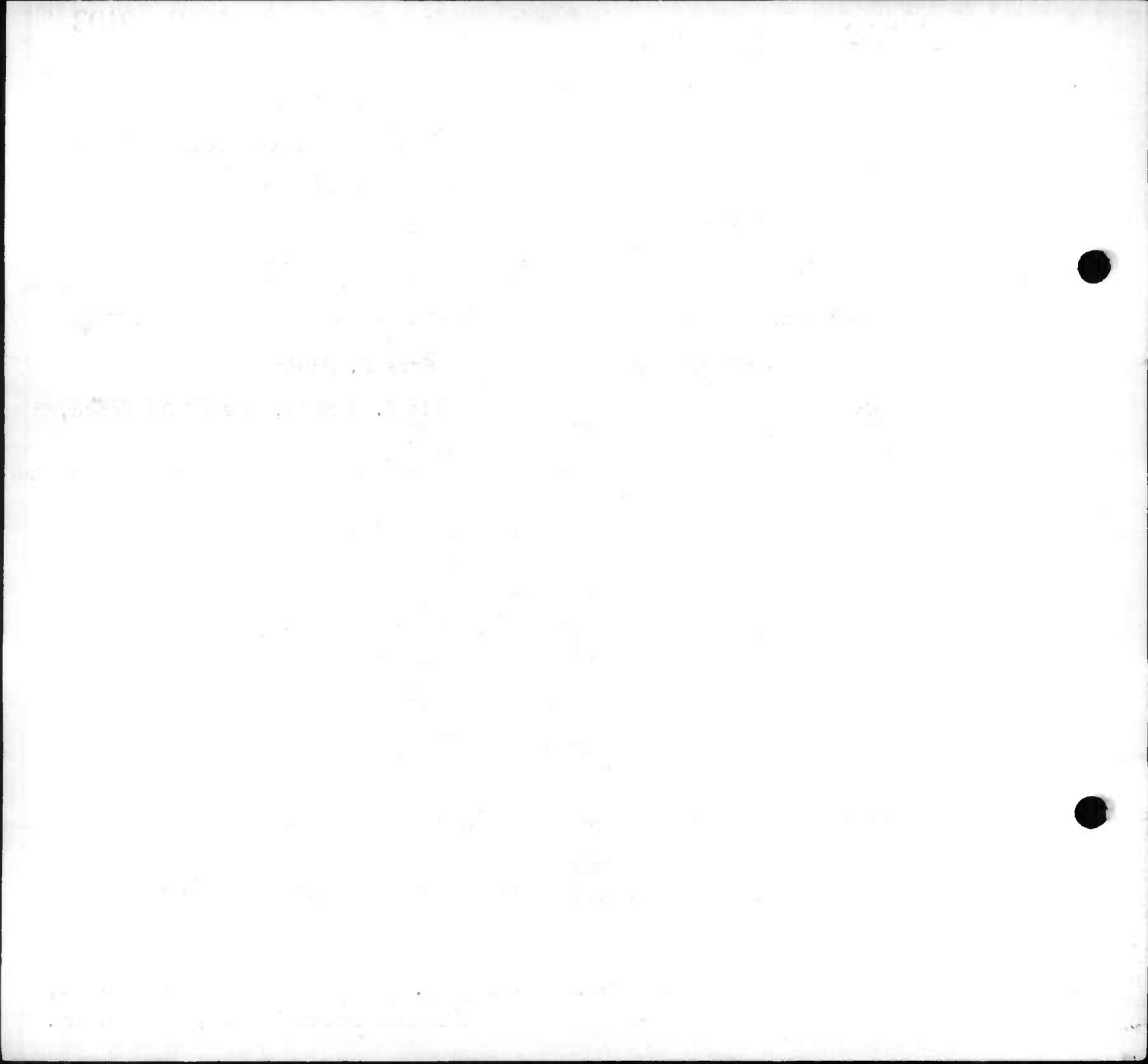
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 09103		72 09103	
C-500		72 09103		72 09103	
BIRTH NO.		72 09103		72 09103	
1. NAME OF DECEASED (Type or Print)		CHANEY, CLARA M.		2. DATE AND HOUR OF DEATH 9/19/72 1:45 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND		B. COUNTY XXXXXX	
FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITY HOSPITAL GREEN ST. BALTIMORE		C. CITY OR TOWN CHESAPEAKE BEACH		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER NONE		5. SEX F		6. RACE W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/15/15		9. AGE (in years last birthday) 57	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hswf Sec.		10B. KIND OF BUSINESS OR INDUSTRY NAVY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME GEORGE KLEIN (Deed)		14. MOTHER'S MAIDEN NAME Mary I. Klein	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. ?		17. INFORMANT Burgess H. Chaney, Chesapeake Beach, Md	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: recent myocardial infarction 6 hours (B) coronary atherosclerosis DUE TO, OR AS A CONSEQUENCE OF: (C) infarction previous Aug. 9, 1972		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) lost saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE John D. Hughes MD		23B. DATE SIGNED 9-19-72		23C. PHYSICIAN'S NAME (Type) John D. Hughes	
23D. ADDRESS Univ. of Maryland Hospital		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE	
24C. NAME of CEMETERY or CREMATORY Mt Harmony Church Cem.		24D. LOCATION (City, town, or county) (State) Owings, Calvert, Md		25A. DATE REC'D BY HEALTH DEPT. SEP 25 1972	
25B. NAME OF REGISTRAR A. J. Hughes		25C. FUNERAL DIRECTOR Buchanan Funeral Home, Owings, Md.		25D. ADDRESS	







# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 09104</b>	
S-552 72 09104				STATE OF MARYLAND-DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
SCHMINK, FRANCIS JOSEPH		9-20-72		4:05 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>23 Veterans Administration Hospital</b> <b>3900 Loch Raven Blvd.,</b> <b>Baltimore, Md. 21218</b>			A. STATE <b>MARYLAND</b> B. COUNTY <b>2843</b>		
			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>4942 Clifton Avenue</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/25/21</b>	9. AGE (In years last birthday) <b>51</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gen. Maintenance</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>LYKENS, PA.</b>	
13. FATHER'S NAME <b>LEO SCHMINK</b>		14. MOTHER'S MAIDEN NAME <b>MARIA KENNEDY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES 1/13/41 to 6/3/42</b>		16. SOCIAL SECURITY NO. <b>227 12 46 86</b>		17. INFORMANT <b>Medical Records</b> <b>VA Hospital, Baltimore, Md. 21218</b>	
18. CAUSE OF DEATH <b>571.0 I</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>SCHIZOPHRENIC, PARANOID</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b> <b>5 years</b> <b>Years</b>		
19A. DATE OF OPERATION <b>2 NONE</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>August 21</b> 19 <b>72</b> to <b>September 20</b> 19 <b>72</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>September 20</b> 19 <b>72</b> and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (did not) view the body after death.					
23A. SIGNATURE <b>X Louis W. Miller M.D.</b>				23B. DATE SIGNED <b>9-20-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>LOUIS W. MILLER, M. D.</b>				23D. ADDRESS <b>VA Hospital, Baltimore, Md. 21218</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>9/23/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>CALVARY UNITED METH</b>	
24D. LOCATION (City, town, or county) (State) <b>WICONICO PA.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 25 1972</b>		25B. NAME OF REGISTRAR <b>Adrian Johnson</b>	
25C. FUNERAL DIRECTOR <b>J.G. CONNELLY</b>		25D. ADDRESS <b>300 MALE</b>			

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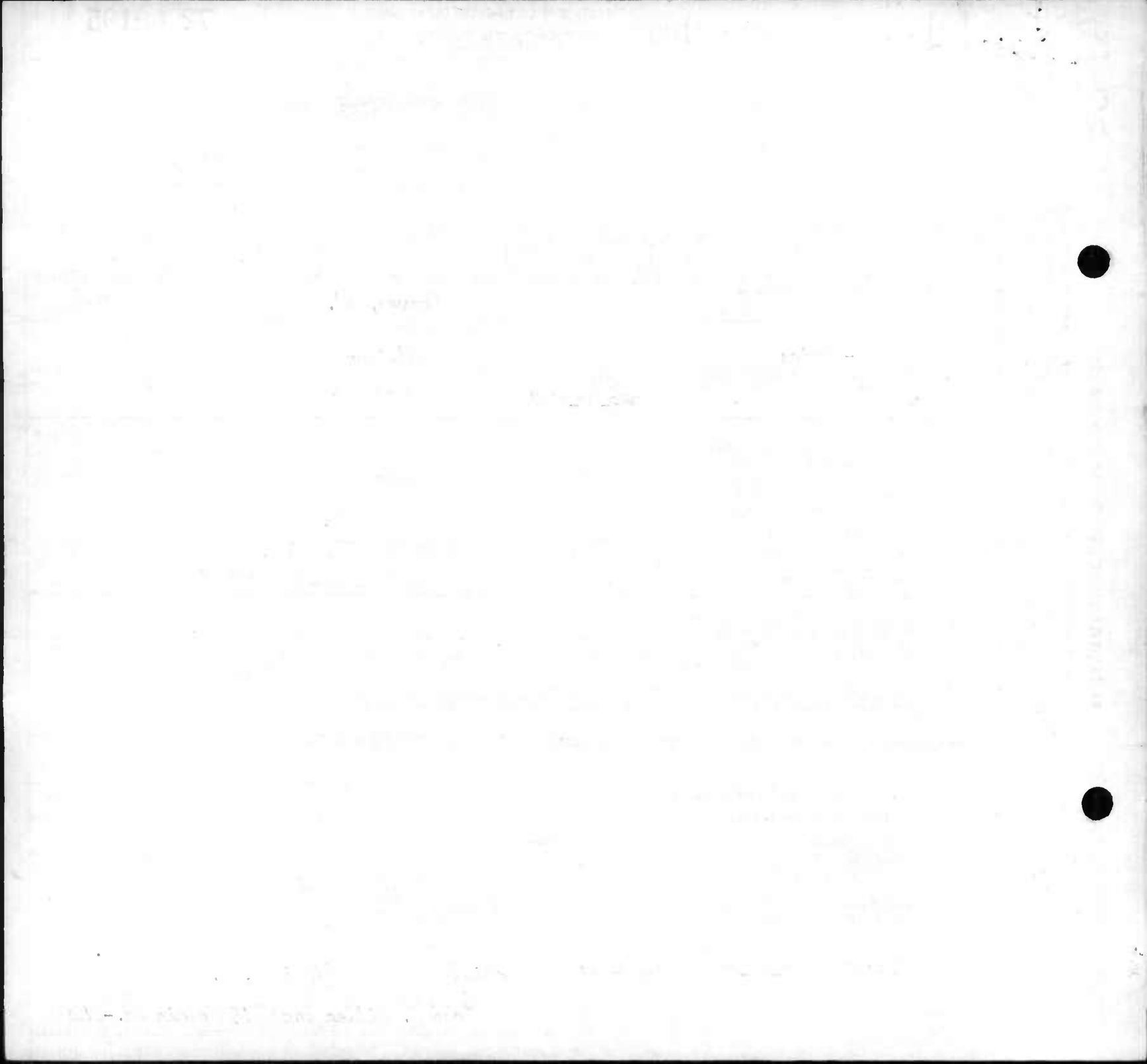
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# FUNERAL DIRECTOR: IMPORTANT

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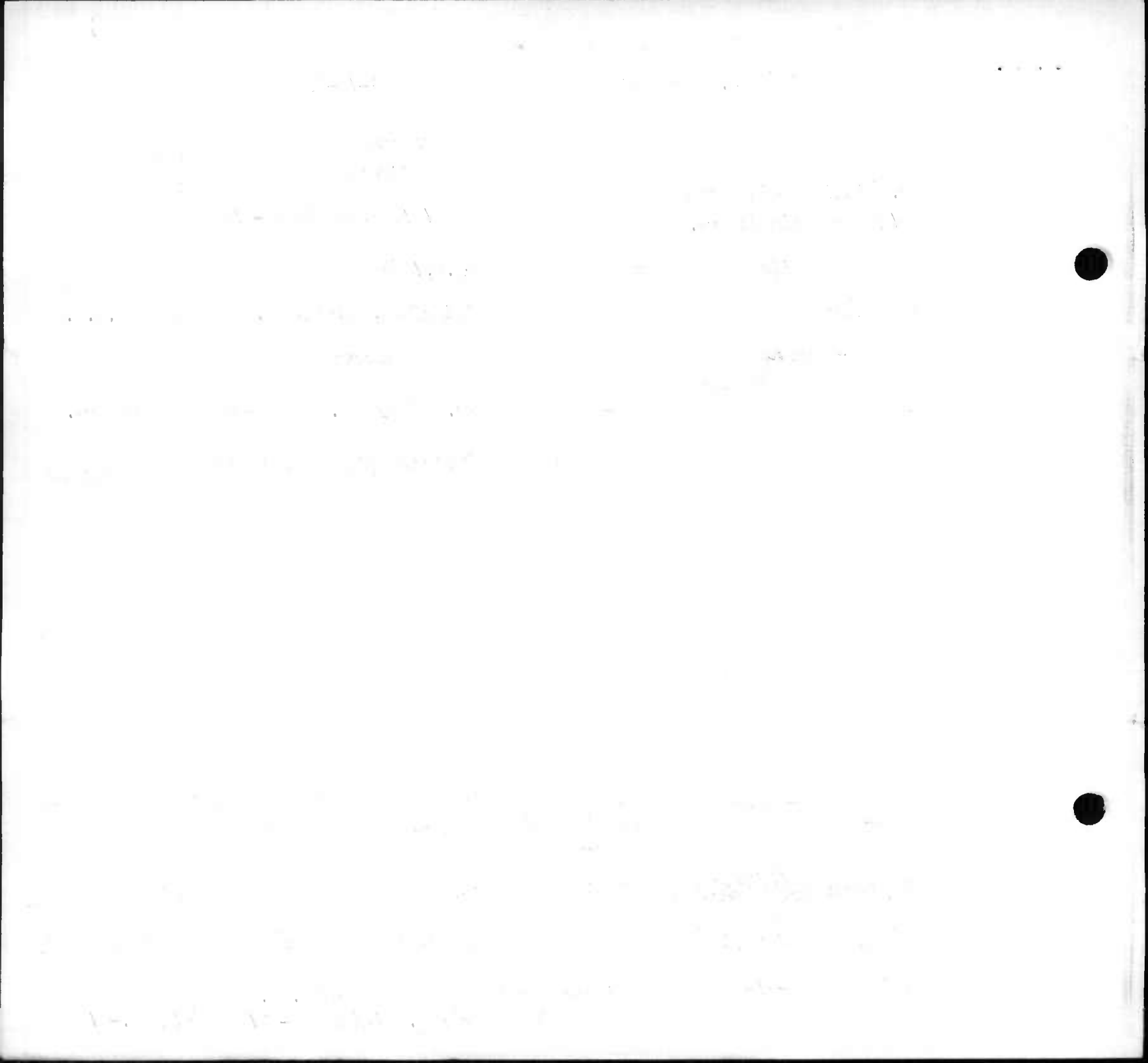
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">72 09105</span>	
J-162 72 09105				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Peggy Bates Jeffers		9/19/72 2:40 A.M.	
3. PLACE IN BALTIMORE MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
Md. General Hospital				Md. 2003	
5. SEX		6. RACE		C. CITY OR TOWN	
F		W		Baltimore	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		D. INSIDE CITY LIMITS?	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		6/11/02		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		E. STREET AND NUMBER	
Housewife				437 S. Alaska St.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
- Bates				Allison	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		263-03-6464		chart	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial infarction					
(B) DUE TO, OR AS A CONSEQUENCE OF: Arterio-sclerotic					
(C) Vascular disease					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
Pulmonary edema Cardiogenic Shock 15 hrs.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Sept 18 1972 to Sept 19 1972 that (I) (we) last saw the deceased alive on Sept 19 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
J. Biddison M.D.				9/19/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
J. Biddison M.D.				Md. General Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		9-20-72		Meadowridge Memorial	
				Elkridge, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
SEP 25 1972		John C. Miller		15 Belair Rd. - 21206	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				72 09106		REG. NO. 72 09106	
BIRTH NO. B-656				72 09106		STATE OF MARYLAND - DIME	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Stella M. Bernhard				9-18-72			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE Maryland			
Mt. Sinai Nursing Home				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
4613 Park Heights Ave.				E. STREET AND NUMBER 1714 Byrd Street-21230			
5. SEX Female		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 9, 1887	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 85		11. BIRTHPLACE (State or foreign country)	
Home Maker				Whiteford, Harford Co.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME - Hughes				14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. -		17. INFORMANT Mrs. Blanche S. Simon - 3442 Kenyon Ave.	
18. 417.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH Arteriosclerotic Heart Disease			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 5 years			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Cerebro-vascular arteriosclerosis 5 years			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (the hospital) attended the deceased from Oct. 1970 to Sept. 18, 1972		that (I) (we) last saw the deceased alive on Sept. 13, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE Marvin Goldstein, M.D. DEGREE				23B. DATE SIGNED Sept. 20, 1972		23C. PHYSICIAN'S NAME (Type) MARVIN GOLDSTEIN DEGREE	
23D. ADDRESS 6001 PARK HEIGHTS AVE. BALTIMORE, MD				24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-21-72	
24C. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery				24D. LOCATION Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 25 1972	
25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR John C. Miller Inc		25D. ADDRESS 6415 Belair Rd. - 21206	

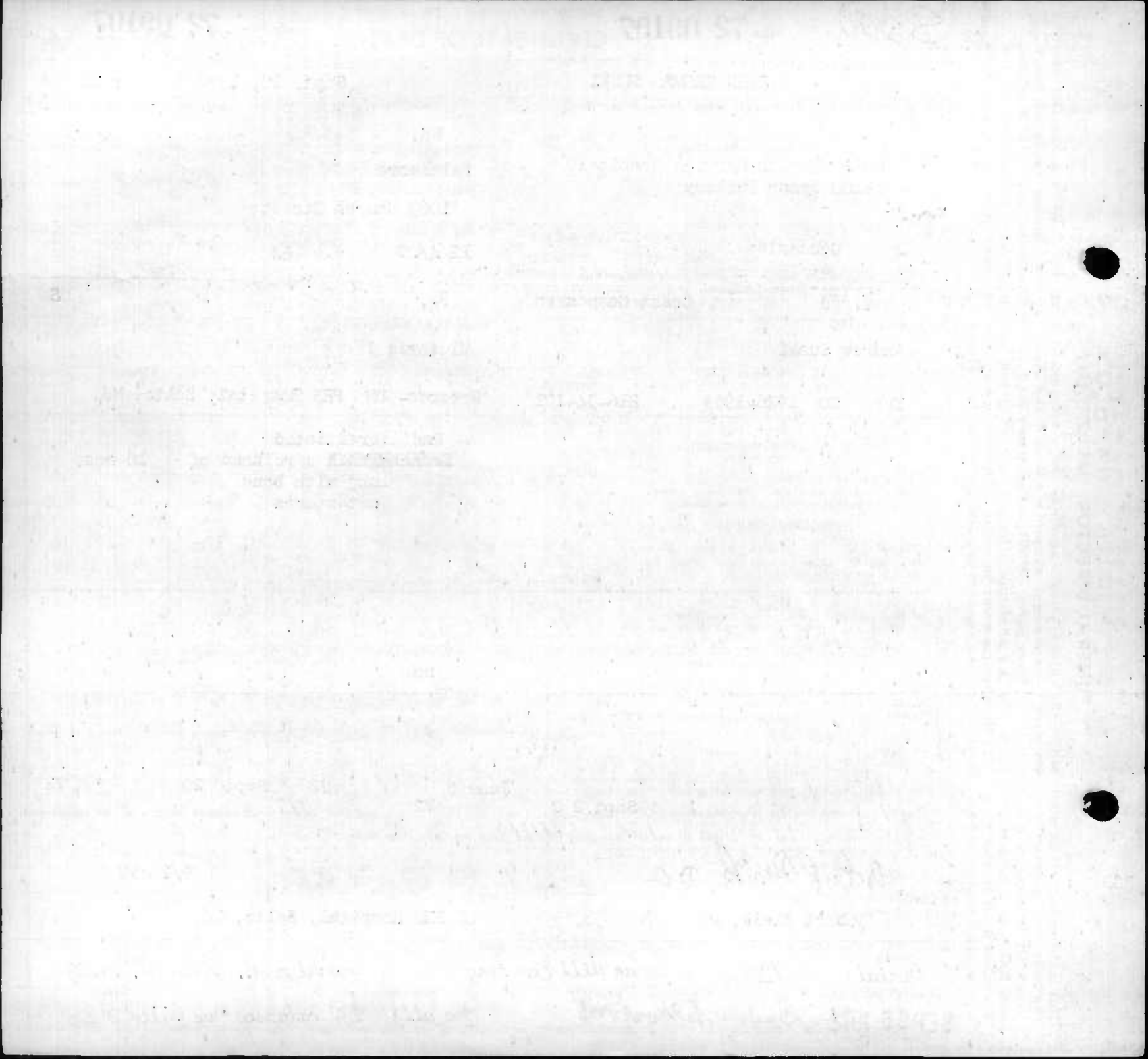


# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. <i>S-200</i>				BALTIMORE CITY HEALTH DEPT. 72 09107				REG. NO. <i>72 09107</i>			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH							
<i>JOHN THOMAS SUSKI</i>				<i>Sept. 20, 1972 2: 25 A.M.</i>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION <i>US Public Health Service Hospital</i> <i>3100 Wyman Parkway</i>				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Md.</i>				A. STATE B. COUNTY			
				C. CITY OR TOWN <i>Baltimore</i>				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER <i>1063 Church Street</i>							
5. SEX <i>M</i>	6. RACE <i>Caucasian</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/4/07</i>	9. AGE (In years last birthday) <i>64</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Coast Guardsman</i>		11. BIRTHPLACE (State or foreign country) <i>Pa.</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Andrew Suski</i>				14. MOTHER'S MAIDEN NAME <i>Victoria ?</i>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes CG 1926-1953</i>				16. SOCIAL SECURITY NO. <i>216-34-1718</i>		17. INFORMANT ADDRESS <i>Records- US PHS Hospital, Balto, Md.</i>					
18. <i>62.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <i>Undifferentiated carcinoma of lung with bone metastasis</i>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 mos.</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:							
(C) _____											
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).											
19A. DATE OF OPERATION <i>0</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <i>no</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that <i>(1)</i> (this hospital) attended the deceased from <i>June 8, 1972</i> to <i>Sept. 20, 1972</i> , that <i>(1)</i> (we) last saw the deceased alive on <i>Sept. 20, 1972</i> and that in <i>(1)</i> (our) opinion death occurred on the date and hour and from the causes stated above <i>(1)</i> (We) (did) <i>(did not)</i> view the body after death.											
23A. SIGNATURE <i>Robert Blaik, D.O.</i>						23B. DATE SIGNED <i>9/20/72</i>					
23C. PHYSICIAN'S NAME (Type) <i>Robert Blaik, DO</i>						23D. ADDRESS <i>US PHS Hospital, Balto, Md.</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>9/22/72</i>		24C. NAME of CEMETERY or CREMATORY <i>Cedar Hill Cemetery</i>			24D. LOCATION (City, town, or county) (State) <i>Brooklyn Md. Balto Md. 21225</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 25 1972</i>			25B. NAME OF REGISTRAR <i>Sidney Thornton</i>			25C. FUNERAL DIRECTOR <i>McCully</i>			ADDRESS <i>237 Patapsco Ave Balto 21225</i>		



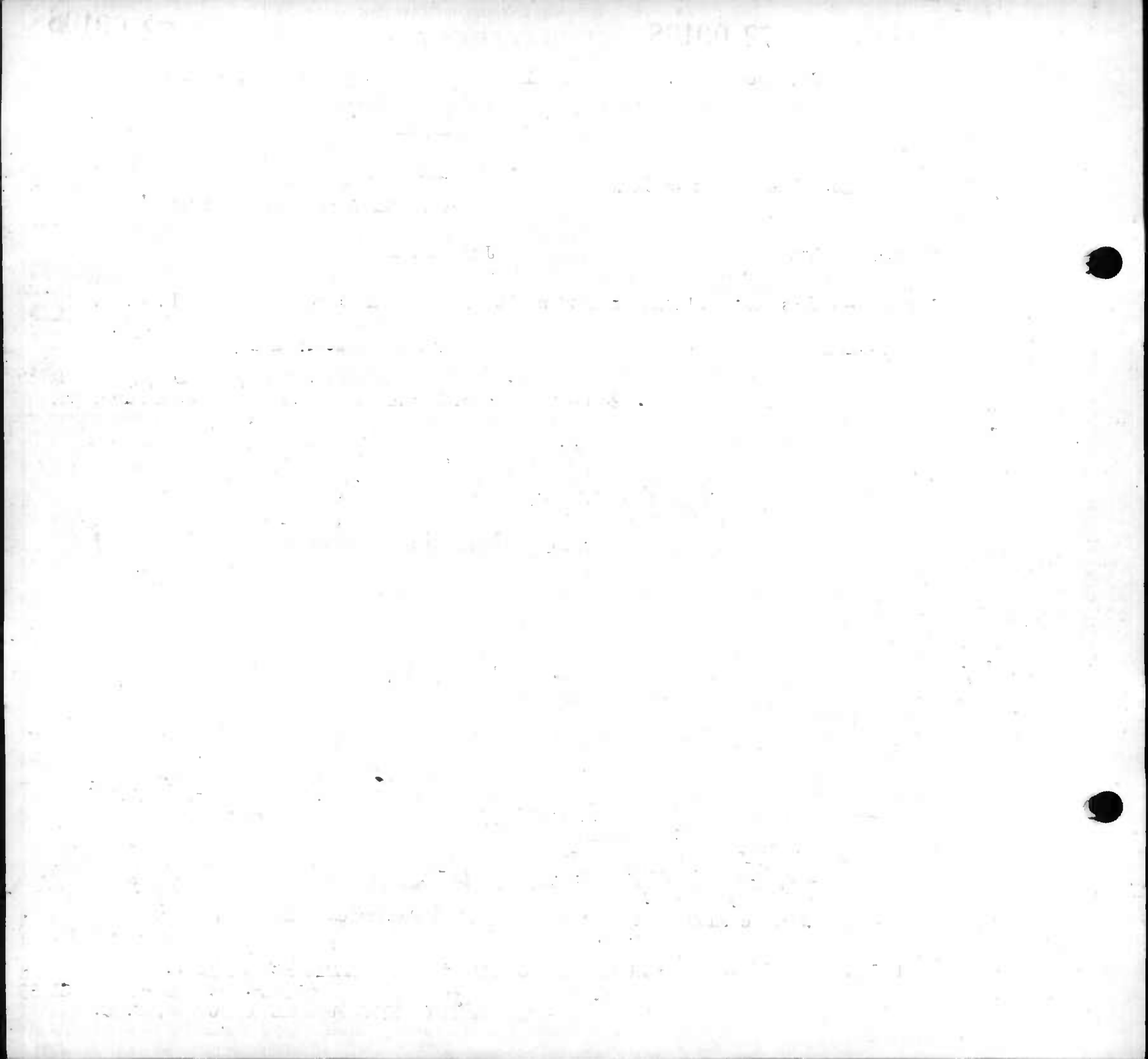




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">72 09108</span>
72 09108				STATE OF MARYLAND - DEATH
BIRTH NO. <span style="font-size: 1.5em;">W-240</span>		72 09108		M.
1. NAME OF DECEASED (Type or Print) Florence S. Weikel		2. DATE AND HOUR OF DEATH September 21, 1972 630 P.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  90 Caton Manor Nursing Home		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1001 Stamford Road 21229		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 28, 1888	9. AGE (In years last birthday) 84
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Sales Lady		10B. KIND OF BUSINESS OR INDUSTRY O'Neal Department Store		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.				
13. FATHER'S NAME William Weikel		14. MOTHER'S MAIDEN NAME Kate (Wackenhagan) Weikel		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. 212-10-4072		17. INFORMANT 104 Severn River Road ADDRESS 21146 Mrs. Elizabeth Windsor Severna Park, Md.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  I Multiple Strokes Hypertensive Cardio-vascular Disease II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months 10 yrs
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from July 18 1972 to 9/21/72 1972, that (I) last saw the deceased alive on 9/21/72 1972 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.				
23A. SIGNATURE <i>W. E. McGrath</i>		23B. DATE SIGNED 9/22/72		23C. PHYSICIAN'S NAME (Type) W. E. McGrath
23D. ADDRESS 1303 Frederick Road		23E. FUNERAL DIRECTOR LORING BYERS FUNERAL DIRECTORS, P. A.		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/23/1972		24C. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEMETERY
24D. LOCATION BALTIMORE, MARYLAND		24E. ADDRESS 8728 Liberty Road 21133		
25A. DATE REC'D BY HEALTH DEPT. SEP 25 1972		25B. NAME OF REGISTRAR <i>Adrienne Johnson</i>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-520		72 09109		BALTIMORE CITY HEALTH DEPARTMENT		72 09109	
BIRTH NO.		72 09109		CERTIFICATE OF DEATH		REG. NO. 72 09109	
1. NAME OF DECEASED (Type or Print) <b>Walter L. Thomas</b>				2. DATE AND HOUR OF DEATH <b>SEPT 19 3:54 PM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNIVERSITY OF MARYLAND HOSPITAL</b>				A. STATE <b>Maryland</b>		B. COUNTY <b>Baltimore</b>	
				C. CITY OR TOWN <b>Dundalk</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <b>2993 Yorkway</b>				F. STREET AND NUMBER <b>2993 YORKWAY</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/26/1909</b>	9. AGE (In years last birthday) <b>63</b>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Marylander Messenger Service</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>WALTER J. THOMAS</b>				14. MOTHER'S MAIDEN NAME <b>SARAH MCQUARY</b>			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>218-18-1258</b>		17. INFORMANT <b>Wife: Mrs. Mary V. Thomas</b>		ADDRESS <b>2993 Yorkway Dundalk, Md. 21222</b>	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <b>CARDIAC ARREST</b>		<b>IMMEDIATE</b>	
				(B) <b>HEMORRHAGE, SEPSIS</b>		<b>14 DAYS</b>	
				(C) <b>LEUKEMIA</b>		<b>6 MONTHS</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>NO</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>NO</b>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>NO</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>NO</b>			
22. I certify that (I) (this hospital) attended the deceased from <b>September 12 19 72</b> to <b>September 19 19 72</b> that (I) (we) last saw the deceased alive on <b>September 19 19 72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Thomas E. Murphy Jr. M.D.</b>				23B. DATE SIGNED <b>9/19/72</b>		23C. PHYSICIAN'S NAME (Type) <b>THOMAS E. MURPHY JR. M.D.</b>	
23D. ADDRESS <b>UNIVERSITY OF Md. HOSPITAL</b>				24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>9-22-72</b>		24C. NAME of CEMETERY or CREMATORY <b>Meadowridge Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Dorsey, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 25 1972</b>		25B. NAME OF REGISTRAR <b>Sidney W. Horton</b>		25C. FUNERAL DIRECTOR <b>John J. Duda</b>			
				ADDRESS <b>7922 Wise Ave. Dundalk, Md. 21222</b>			

10/10/18

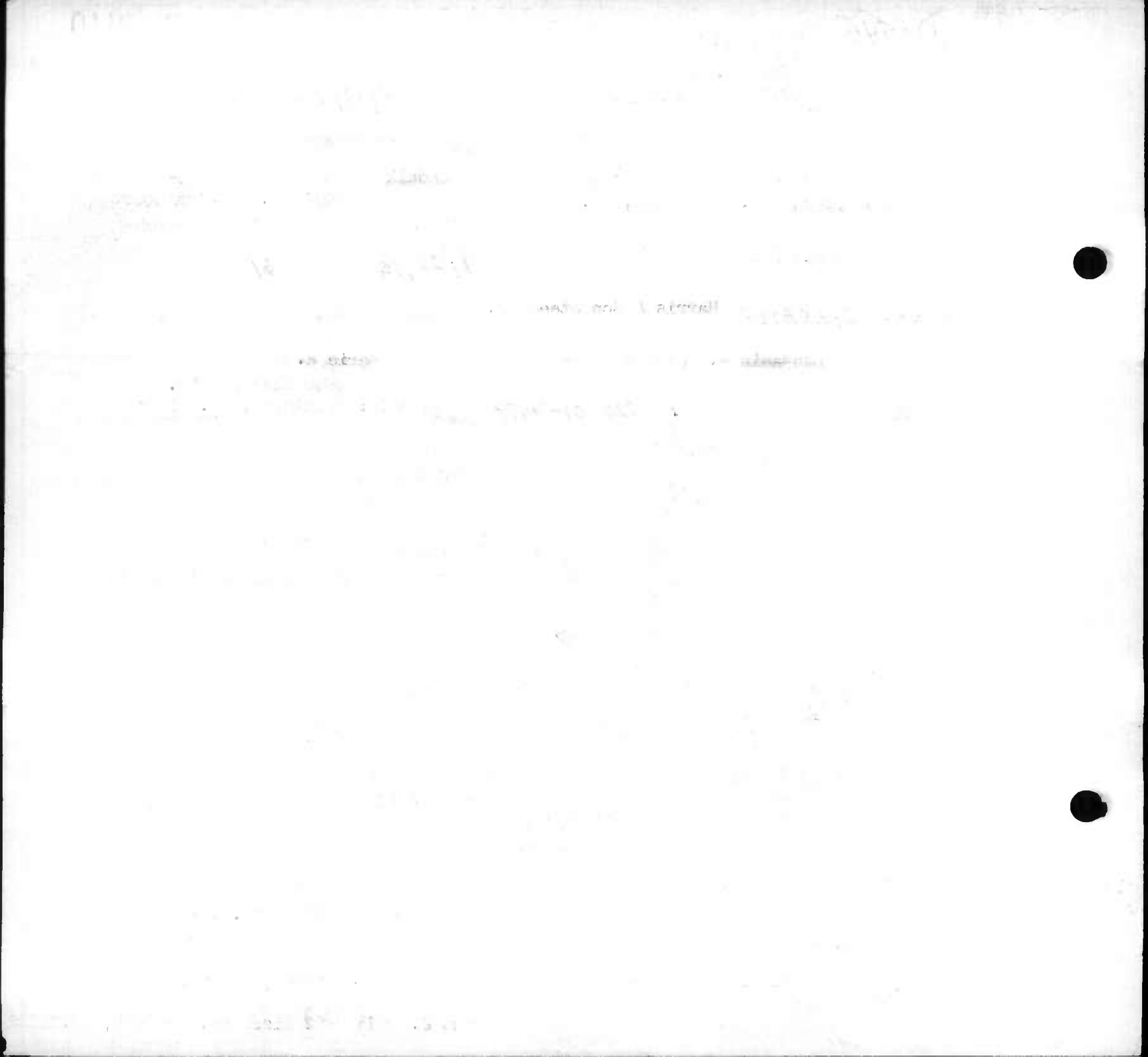
WATKINS

Yours truly,

W. J. Watkins

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
D-545 72 09110		CERTIFICATE OF DEATH		72 09110	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		STATE OF MARYLAND	
Paul C. Denlein PAUL DENLEIN		9/18/72 3:05 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)		M. STATE	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
BALTIMORE CITY HOSP		MD		Baltimore	
4940 Eastern Ave. Baltimore, Md. 21224		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Dundalk		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER		7419 St. Patricia Court	
				7419 ST PATRICIA LANE	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
Male	Caucasian	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9/22/10	61	11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
STEEL OPERATOR		Harris & Son Steel Co.		MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Benjamin P. Denlein		Marie A.		U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		220-01-4079		4940 Eastern Ave. ADDRESS	
				BCH Records: Baltimore, Md. 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of death, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		METASTASIS FROM		7 months.	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) showing the UNDERLYING CONDITION lost.		CANCER OF KIDNEY			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		CANCER OF KIDNEY			
		(C) Fx RT HIP (Pathological Fr)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A)					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
9/21/72		FRACTURE RT HIP		No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
No		HOME		HOME - Above address	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
9 17 72		While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		Fell down at home	
22. I certify that (I) (this hospital) attended the deceased from 8/17/72 to 9/18/72 19 that (I) (we) last saw the deceased alive on 9/18/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
A.W. March MD		9/18/72			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
ALLAN W. MARCH		4940 Eastern Ave. 21224			
		Baltimore City Hospital			
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		9-22-72		Oak Lawn Cemetery	
24D. LOCATION (City, town, or county) (State)		24E. NAME of REGISTRAR		24F. FUNERAL DIRECTOR	
Baltimore, Maryland				John J. Duda	
25A. DATE OF DEATH		25B. NAME of REGISTRAR		25C. FUNERAL DIRECTOR	
SEP 25 1972				John J. Duda	
				ADDRESS	
				7922 Wise Ave. Dundalk, Md. 21222	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09111		72 09111	
C-200 72 09111				CERTIFICATE OF DEATH		REG. NO. STATE OF MARYLAND-DMH	
1. NAME OF DECEASED (Type or Print) <b>SOPHIA CZACZKA</b>				2. DATE AND HOUR OF DEATH <b>SEPT. 15, 1972 10:00A M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SOUTH BALTIMORE GENERAL HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTIMORE</b>			
5. SEX <b>FEMALE</b> 6. RACE <b>WHITE</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>Oct. 24, 1888</b>		9. AGE (In years last birthday) <b>83</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (State or foreign country) <b>POLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>ZAHARKO</b>			
14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			
16. SOCIAL SECURITY NO. <b>213 74 9098</b>				17. INFORMANT <b>Mrs. Amelia Dorosz, 1103 Church St.</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>SHOCK</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>SEPTICEMIA</b>				(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) <b>PNEUMONIA</b>							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>ARTERIO SCLEROTIC HEART DISEASE</b>							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>September 14, 1972</b> to <b>September 15, 1972</b> that (I) (we) last saw the deceased alive on <b>Sept. 15, 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Roberto C. Feliciano</b>				23B. DATE SIGNED <b>9/15/72</b>			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>9/19/72</b>		<b>Holy Cross Cemetery</b>		<b>A.A.Co, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 25 1972</b>		25B. NAME OF REGISTRAR <b>George J. Gonce</b>		25C. FUNERAL DIRECTOR <b>George J. Gonce</b>		ADDRESS <b>4001 Ritchie Hwy</b>	

Case 15-0011

HOSPITAL

WHITE

NAME

POUND

UNKNOWN

NO

2 HOOK

SEPTICEMIA

PNEUMONIA

ARTERIO-SCLEROTIC HEART DISEASE

Robert C. Williams

✓



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09112	
S-455 72 09112				STATE OF MARYLAND-DEMH	
BIRTH NO.		NAME OF DECEASED (Type or Print)		DATE AND HOUR OF DEATH	
		Charles Raymond Solomon		September 19, 1972 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
38 University Hospital			Maryland Baltimore 5300		
5. SEX Male			6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 12, 1899 73
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)
Retired - B & O Railroad					73
11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Maryland			U. S. A.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Charles S. Solomon			Margaret A. Rogers		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT
No None			705-05-2945		Mrs. Mildred Louise Solomon same as 4E Mr. Charles S. Solomon 1801 Dalhouse Cr. 34
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
410.9 I			Gentle cerebral infarction		
ANTECEDENT CAUSES			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			ASCVD		
II			(B) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			(C)		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 9/18 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE LH Golombek				23B. DATE SIGNED 9/20/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Leonard H. Golombek				7039 Liberty Road	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
BURIAL		9.22.1972		Druid Ridge Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
SEP 25 1972		Sidney H. H. H. H.		8728 Liberty Road ADDRESS 21133	
LORING BYERS FUNERAL DIRECTORS, P. A.					

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>H-155</b>				BALTIMORE CITY HEALTH DEPARTMENT				72 09113				CERTIFICATE OF DEATH				REG. NO. <b>72 09113</b>							
1. NAME OF DECEASED (Type or Print) <b>James Watson Hoffman</b>								2. DATE AND HOUR OF DEATH <b>Sept. 18, 1972 8:36 PM</b>															
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>US Public Health Service Hospital 3100 Wyman Parkway</b>								4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>CAROLINE</b>															
5. SEX <b>M</b>				6. RACE <b>Caucasian</b>				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>8/8/36</b>				9. AGE (In years last birthday) <b>36</b>							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>								10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>James Hoffman</b>								14. MOTHER'S MAIDEN NAME <b>Cecelia Fishell</b>															
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes USN 1955-1959</b>								16. SOCIAL SECURITY NO. <b>214-34-5241</b>				17. INFORMANT ADDRESS <b>Records- US PHS Hospital, Balto, Md.</b>											
18. CAUSE OF DEATH																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Septicemia</b>																Days							
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)																							
ANTECEDENT CAUSES																							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.																							
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:																							
(B) DUE TO, OR AS A CONSEQUENCE OF:																							
(C) DUE TO, OR AS A CONSEQUENCE OF:																							
II																							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).																							
Renal failure Hodgkin's disease																							
Weeks 9 yrs.																							
19A. DATE OF OPERATION								19B. CONDITION FOR WHICH OPERATION WAS PERFORMED															
20A. AUTOPSY? (Yes or No) <b>YES</b>								20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>															
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)								21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)								21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)								21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>								21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from <b>July 31</b> 19 <b>72</b> to <b>Sept. 18</b> 19 <b>72</b> , that (I) (we) lost saw the deceased alive on <b>Sept. 18</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																							
23A. SIGNATURE <i>Robert Wright</i>								23B. DATE SIGNED <b>9/19/72</b>															
23C. PHYSICIAN'S NAME (Type) <b>Robert Wright, Surgeon (R)</b>								23D. ADDRESS <b>US PHS Hospital, Balto, M d. 21211</b>															
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>								24B. DATE <b>SEP 25 1972</b>								24C. NAME of CEMETERY or CREMATORY <b>CONCORD</b>							
24D. LOCATION (City, town, or county) (State) <b>CONCORD CAROLINE MD</b>								25A. DATE REC'D BY HEALTH DEPT. <b>SEP 25 1972</b>								25B. NAME OF REGISTRAR <i>Andrew Johnson</i>							
25C. FUNERAL DIRECTOR <b>ELIAS V. MOORE</b>								25D. ADDRESS <b>DENTON MD</b>															

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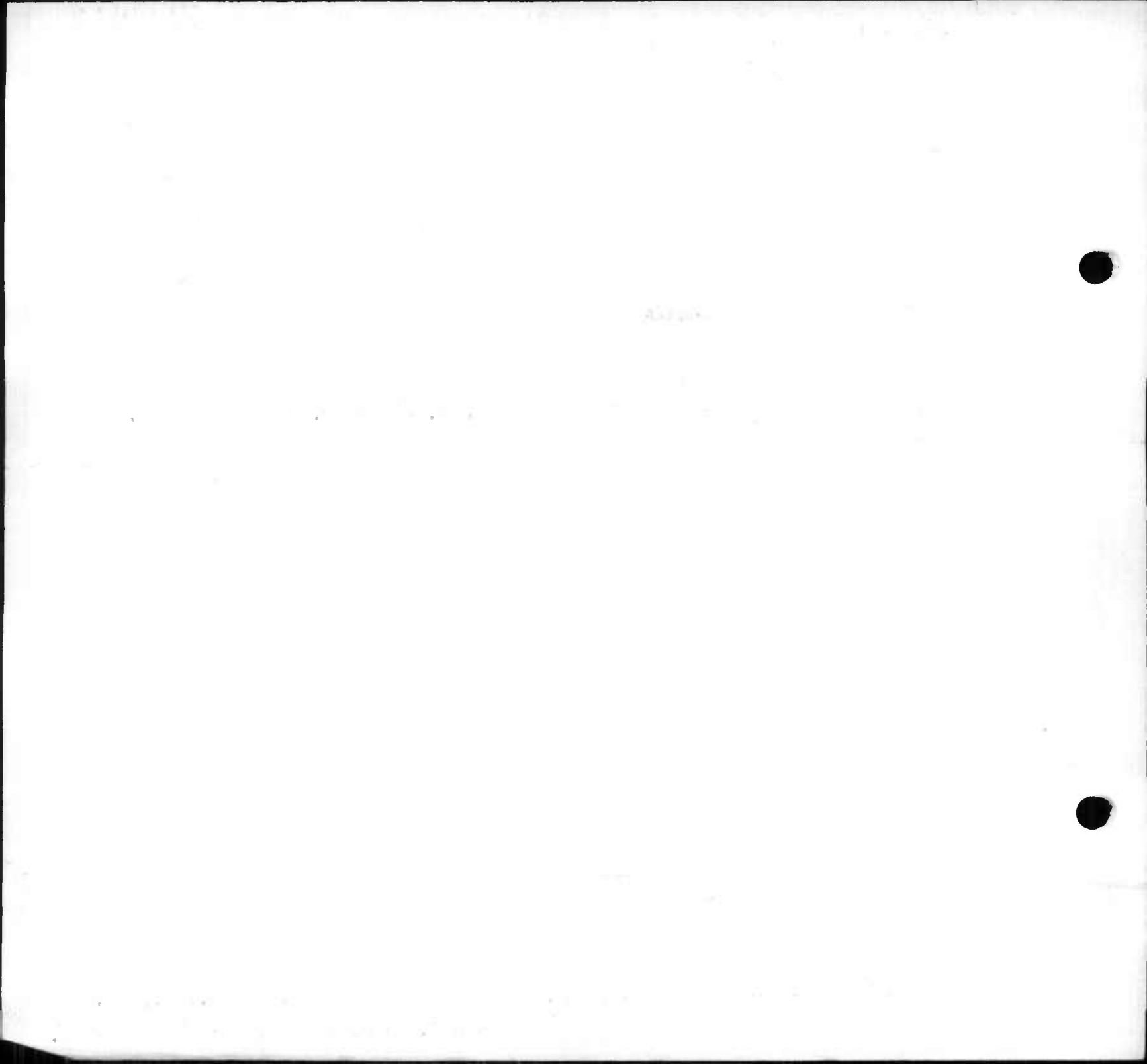
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09114	
CERTIFICATE OF DEATH				REG. NO. 72 09114	
BIRTH NO. <b>K-400</b>		72 09114		STATE OF MARYLAND-DEMD	
1. NAME OF DECEASED (Type or Print) <b>Kelly, John Albert</b>		2. DATE AND HOUR OF DEATH <b>9-20-72 10:30 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Univ. of Maryland Hosp.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>BALTO</b>			
5. SEX <b>M</b>		6. RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>engineer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>westinghouse</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>John Kelly</b>		14. MOTHER'S MAIDEN NAME <b>Mary -</b>			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes june 1919 july 1925</b>		16. SOCIAL SECURITY NO. <b>220 18 6402</b>		17. INFORMANT <b>John A. Kelly Jr.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>284 X</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>pneumonia &amp; pleural effusion</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>refractory anemia</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>9-23-72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>myocardial infarction</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9-16</b> 19 <b>72</b> to <b>9-20</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>9-20</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>John Hughes MD</b>		23B. DATE SIGNED <b>9-20-72</b>		23C. PHYSICIAN'S NAME (Type) <b>John Hughes</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>9-23-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn</b>	
25A. DATE RECEIVED BY HEALTH DEPT. <b>SEP 25 1972</b>		25B. NAME OF REGISTRAR <b>John T. Stansbury</b>		25C. FUNERAL DIRECTOR ADDRESS <b>6411 Windsor Mill Rd.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-242 72 09115				BALTIMORE CITY HEALTH DEPARTMENT		72 09115	
CERTIFICATE OF DEATH				REG. NO.		STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print) <b>Bikuls, Joseph</b>				2. DATE AND HOUR OF DEATH <b>Sept. 20, 1972 9:30 PM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>The Union Memorial Hosp.</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3829 Monterey Rd</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-18-85</b>	9. AGE (In years last birthday) <b>87</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sailor</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Litho</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-09-5599</b>		17. INFORMANT <b>Auna Bikuls</b>		ADDRESS <b>3829 Monterey Rd Baltimore M.D.</b>	
18. <b>599.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>Renal failure</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Urinary tract infection</b>				(B) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>pul. embolism, CHF, pneumonia</b>				(C) DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Sept. 7 1972</b> to <b>Sept. 20 1972</b> , that (I) (we) last saw the deceased alive on <b>Sept. 20 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Chung Hsien Yu M.D.</b>				23B. DATE SIGNED <b>Sept 20, '72</b>			
23C. PHYSICIAN'S NAME (Type) <b>CHUNG-HSIEN YU M.D.</b>				23D. ADDRESS <b>The Union Memorial Hosp. Baltimore, Maryland 21218</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>9/23/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Most Holy Redeemer</b>		24D. LOCATION (City, town, or county) (State) <b>Balair Rd. - BALTIMORE</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 25 1972</b>		25B. NAME OF REGISTRAR <b>Audrey W. K...</b>		25C. FUNERAL DIRECTOR <b>Thomas J. KENNY Inc. 1600 Hollins</b>		ADDRESS	



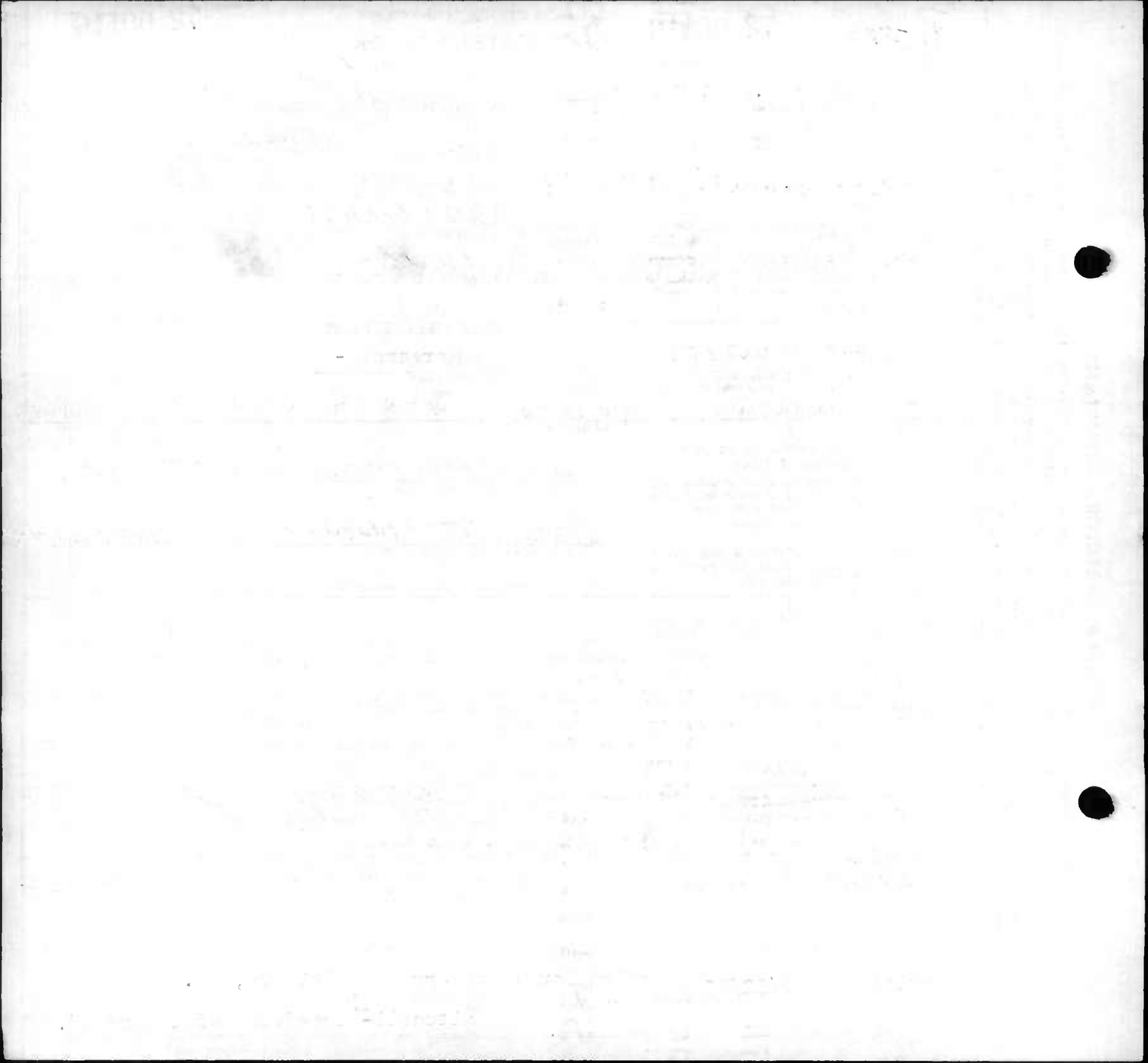




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

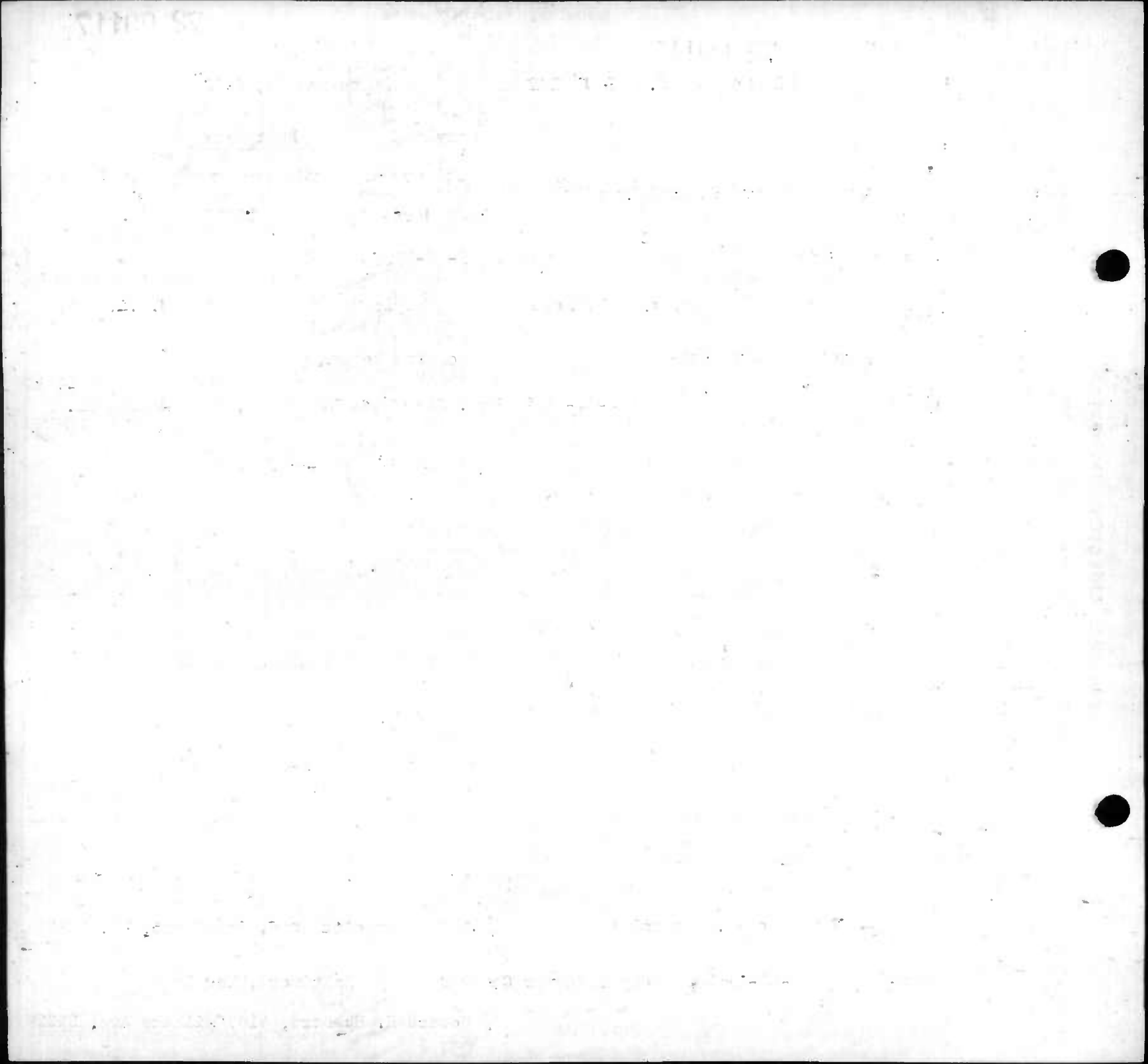
BALTIMORE CITY HEALTH DEPARTMENT		72 09116	
CERTIFICATE OF DEATH		REG. NO. 72 09116	
BIRTH NO. <b>R-246</b>		STATE OF MARYLAND-DEMD	
1. NAME OF DECEASED (Type or Print) <b>EDNA M. REISLER</b>		2. DATE AND HOUR OF DEATH <b>SEPT 19, 1972 10:40 PM.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>MARYLAND GENERAL HOSPITAL</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3027 OAKHILL AVE</b>	
5. SEX <b>FEMALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/14/1884</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	
11. BIRTHPLACE (State or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry MENTZEL</b>		14. MOTHER'S MAIDEN NAME <b>Margaret -</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <b>No</b>		16. SOCIAL SECURITY NO. <b>216 10 9085</b>	
17. INFORMANT <b>John H. WARD</b>		ADDRESS <b>3027 OAKHILL AVE</b>	
18. <b>569.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>Cardio Respiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Chronic GI. bleeding</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>II</b>			
19A. DATE OF OPERATION <b>NONE</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NONE</b>	
20A. AUTOPSY? (Yes or No) <b>NONE</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) <b>NONE</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>NONE</b>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>NONE</b>			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <b>NONE</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <b>Sept 19 19 72</b> to <b>Sept 19 19 72</b> that (1) (we) last saw the deceased alive on <b>Sept 19 19 72</b> and that in (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Robert A. Cooper</b>		23B. DATE SIGNED <b>9/19/72</b>	
23C. PHYSICIAN'S NAME (Type) _____		23D. ADDRESS _____	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/22/72</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 25 1972</b>		25B. NAME OF REGISTRAR <b>Mitchell-Wiedefeld</b>	
25C. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld</b>		ADDRESS <b>6500 York Rd.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09117
CERTIFICATE OF DEATH				STATE OF MARYLAND - DHMH
BIRTH NO. 6-236		72 09117		
1. NAME OF DECEASED (Type or Print)		PIERCE J. LAUKAITIS		2. DATE AND HOUR OF DEATH September 17, 1972
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore General Hospital		A. STATE Maryland B. COUNTY Baltimore		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore Highlands D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
		E. STREET AND NUMBER 2741 Norfen Road 21227		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-4-1909	9. AGE (In years last birthday) 63
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY City of Baltimore		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Ambrose Laukaitis		14. MOTHER'S MAIDEN NAME Sophia Bogdan		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-40-5726		17. INFORMANT ADDRESS Mrs. Josephine Laukaitis, 2741 Norfen Rd. 21227
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Bacterial Pneumonia</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Cirrhosis of the liver</i> (C) DUE TO, OR AS A CONSEQUENCE OF: <i>Diabetes Mellitus with Polyneuropathy</i>		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from September 15 1972 to September 17 1972, that (I) (we) last saw the deceased alive on September 17 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>F. Queral</i>		23B. DATE SIGNED 9/19/72		
23C. PHYSICIAN'S NAME (Type) Fernando D. Queral		23D. ADDRESS 3927 Annapolis Road, Baltimore, Md. 21227		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-21-1972		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland				
25A. DATE REC'D BY HEALTH DEPT. SEP 25 1972		25B. NAME OF REGISTRAR <i>Sidney Whitson</i>		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09118	
72 09118				STATE OF MARYLAND-DEATH	
BIRTH NO. <b>E-242</b>		1. NAME OF DECEASED (Type or Print) <b>ROBERT B. ECKELS</b>		2. DATE AND HOUR OF DEATH <b>September 19, 1972 7 A M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>2037 Hollins Ferry Road Baltimore, Maryland 21230</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2553</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2037 Hollins Ferry Road 21230</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-27-1890</b>	9. AGE (In years last birthday) <b>82</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>B.O.R.R.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Alfred Eckels</b>		
14. MOTHER'S MAIDEN NAME <b>Emma Gassaway</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>705-05-6030</b>			17. INFORMANT ADDRESS <b>Mrs. Naomi Smith, 604 Ashington Road 21061</b>		
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Thrombosis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) Anterior wall Myocardial Infarction</b> <b>(C)</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>9/18</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/23 1972</b> to <b>9/19 1972</b> , that (I) (we) last saw the deceased alive on <b>9/18 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>John P. Urlock, Jr.</b>				23B. DATE SIGNED <b>9/20/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>John P. Urlock, Jr.</b>				23D. ADDRESS <b>1227 Washington Blvd., Balto., Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-22-1972</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 25 1972</b>			
25B. NAME OF REGISTRAR <b>Howard H. Hubbard</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>			

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		72 09119		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09119	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
LEWIS, WILLIAM F, JR				SEPTEMBER 20, 1972 3:20 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
40 ST. AGNES HOSPITAL				MARYLAND		ANNE ARUNDEL	
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				PASADENA		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER			
				7026 FORT SMALLWOOD RD 21122			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months: Days	
MALE	CAUCASIAN	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		01/13/13	59		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
CHAUFFEUR				TRANSPORTATION CO		MARYLAND U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
WILLIAM LEWIS Sr.				CLARA Marie Louise Reinecke			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NONE				213-01-7936		ST. AGNES HOSPITAL RECORDS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				NO			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from JULY 5 19 72 to SEPTEMBER 20 1972, that (I) (we) last saw the deceased alive on SEPTEMBER 20 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
				9/20/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
A. A. FARHAT, M.D.				BALTIMORE, MD 21229			
				ST. AGNES HOSPITAL; CATON & WILKENS AVE			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		9/23/72		Meadowridge Memorial Park		Howard County, Donsey Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
SEP 25 1972		Arlene W. Horton		Mc Cully Funeral Home		21225 237 Patapsco Ave.	







FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">72 09120</span>	
P-456 72 09120				STATE OF MARYLAND-DEATH	
1. NAME OF DECEASED (Type or Print)		John Robert Palmer		2. DATE AND HOUR OF DEATH Sept. 21, 1972 6 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  US Public Health Service Hospital 3100 Wyman Parkway			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Va. B. COUNTY C. CITY OR TOWN Arlington D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2706 N. Oakland St.		
5. SEX M	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/29/52	9. AGE (In years lost birthday) 20	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance man		10B. KIND OF BUSINESS OR INDUSTRY Arlington County		11. BIRTHPLACE (State or foreign country) D.C.	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME John L. Palmer		
14. MOTHER'S MAIDEN NAME Ethel Nelson			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 228-74 5343			17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.		
18. CAUSE OF DEATH					
18A. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)  Metastatic carcinoma of lungs, brain & liver				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months	
18B. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  Choriocarcinoma of right testis				15 months	
18C. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug. 28 19 72 to Sept. 21 19 72, that (I) (we) last saw the deceased alive on Sept. 21 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert E. Belliveau				23B. DATE SIGNED 9/22/72	
23C. PHYSICIAN'S NAME (Type) Robert E. Belliveau, Surgeon (R)				23D. ADDRESS US PHS Hospital, Balto, Md. 21211	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 9/22/72		24C. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory	
24D. LOCATION Alexandria, Virginia		25A. DATE REC'D BY HEALTH DEPT. SEP 25 1972			
25B. NAME OF REGISTRAR Sidney Johnson		25C. FUNERAL DIRECTOR Arlington Funeral Home 3901 No. Fairfax Dr. Arl., Va.			

75-10150

75-10150

IN WITNESS WHEREOF, I have hereunto set my hand and the seal of the Federal Bureau of Investigation, at Washington, D.C., this 1st day of May, 1954.

Special Agent in Charge

John A. Tamm

Attorney General

Department of Justice

Washington, D.C.

Very truly yours,

Special Agent in Charge

Enclosed for the Bureau are two copies of a letterhead memorandum dated and captioned as above.

Very truly yours,

*[Signature]*

Robert E. Ladd, Director (S)

cc: The Bureau, Bureau of Investigation

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09121	
K-300 72 09121				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		STATE OF MARYLAND	
KOETHE, MINNIE M.		9/21/72		8:20 a.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
LUTHERAN HOSPITAL OF MARYLAND			MD. 1301		
5. SEX			6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Female			White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Practical Nurse		Nursing		11/20/1883	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		9. AGE (In years last birthday)	
Unknown		Unknown		88	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country)	
no		218-40-0636		Md.	
18. CAUSE OF DEATH		17. INFORMANT		12. CITIZEN OF WHAT COUNTRY?	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		Mrs. Dorothy J. Simon		U. S. A.	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Box 167		ADDRESS	
ANTECEDENT CAUSES		Mrs. Dorothy J. Simon		Glen Arm, Md.	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		19. DATE OF OPERATION		20A. AUTOPSY? (Yes or No)	
II		19A. DATE OF OPERATION		NO	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/8/72 to 9/21/72 that (I) (we) last saw the deceased alive on 9/21 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)
[Signature]			9/21/72		Bisoy Kumar GHOSH
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify)
Bisoy Kumar GHOSH			LUTHERAN HOSPITAL OF MARYLAND		Burial
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE		24C. NAME of CEMETERY or CREMATORY
Burial			9-23-1972		Loudon Park
24B. DATE			24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)
9-23-1972			Loudon Park		Baltimore, Md.
24C. NAME of CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT.
Loudon Park			Baltimore, Md.		SEP 25 1972
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR
SEP 25 1972			[Signature]		[Signature]
25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR		ADDRESS
[Signature]			[Signature]		3207 W North Ave

10/31/72 - Date of operation - 9/13/72

operation - D. K. ampt. rt. leg.

for gangrene of rt. foot

Letter in file - Bur. of Biostatistics  
from Lutheran Hosp. *92*

3/25/69

2527 Brookfield Ave

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 09122</b>
<b>B-622</b> <b>72 09122</b> <b>CERTIFICATE OF DEATH</b>		<b>72 09122</b> <b>CITY OF MARYLAND - DEATH</b>		
1. NAME OF DECEASED (Type or Print) <b>Bergesen, Hannah M.</b>		2. DATE AND HOUR OF DEATH <b>9-22-72</b> <b>11:15 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>48 Maryland Gen. Hospital,</b> <b>827 Linden Avenue,</b> <b>Baltimore, Md 21201.</b>		A. STATE <b>MD.</b> B. COUNTY <b>2633</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3110 BRENDAN AVE. 21213</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>19 FEB 00</b>	9. AGE (in years lost birthday) <b>72</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>REPRESENTATIVE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>CREDIT BUREAU</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>ANDREW BERGESEN</b>		
14. MOTHER'S MAIDEN NAME <b>EMMA FUCHS</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO. <b>220-17-7058</b>		17. INFORMANT <b>HARRY M. BERGESEN, 4255 JIMMELMAN AVE. 21206</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardiac Arrest</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1-2 hours</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Myocardial Infarction</b>		DUE TO, OR AS A CONSEQUENCE OF: <b>1-2 hours</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Rheumatic Heart Disease</b>		YEARS <b>Years</b>		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>9-22-72</b> 19 <b>9-22-1972</b> to <b>9-22-1972</b> and that (I) (we) last saw the deceased alive on <b>9-22-1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Ahmad</b> M.D. DEGREE		23B. DATE SIGNED <b>9-22-72</b>		23C. PHYSICIAN'S NAME (Type) <b>Dr. Ahmad</b> M.D. DEGREE
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>26 SEP 72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>PARKWOOD CEMETERY</b>
24D. LOCATION (City, town, or county) (State) <b>BALTO. CO., MD.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 25 1972</b>		
25B. NAME OF REGISTRAR <b>Spring</b>		25C. FUNERAL DIRECTOR <b>OLDRICH FUNERAL HOME, BALTO, MD 21206</b>		

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>B-100</span> <span>72 09123</span> </div>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. <b>72 09123</b> STATE OF MARYLAND-DEMM	
BIRTH NO. _____		1. NAME OF DECEASED (Type or Print) <b>ROPEY EUGENE</b>		2. DATE AND HOUR OF DEATH <b>SEPT 19 1972 11:55 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SDUTH 43 BALTIMORE GENERAL HOSP</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY _____		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>M</b> 6. RACE <b>W</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-21-88</b> 9. AGE (In years last birthday) <b>84</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard</b> 10B. KIND OF BUSINESS OR INDUSTRY <b>Md. National Bank</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Unknown</b> 14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) _____ 16. SOCIAL SECURITY NO. <b>212-16-0646</b>	
17. INFORMANT <b>Mrs Thelma D. Elms 4606 Pen Lucy Rd.</b> ADDRESS _____		18. <b>436.9 I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>PNEUMONIA</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CEREBRO-VASCULAR ACCIDENT</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). _____					
19A. DATE OF OPERATION _____ 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) _____ 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____		MEDICAL CERTIFICATION	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) (this hospital) attended the deceased from <b>9-10</b> 19 <b>72</b> to <b>9-19</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>9-19</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Virma V. Torres</b> M.D. DEGREE				23B. DATE SIGNED _____	
23C. PHYSICIAN'S NAME (Type) <b>Virma V. Torres</b>		23D. ADDRESS <b>2506 W. PATAPSCO AVE APT-1-C BALT. M.D.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/23/1972</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 25 1972</b> 25B. NAME OF REGISTRAR <b>Andrew H. Norton</b> 25C. FUNERAL DIRECTOR'S ADDRESS <b>G. Truman Schwab 3512 Frederick Ave.</b>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 09124		72 09124	
C-200		72 09124		72 09124	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH (State of Maryland - Death)	
		Raymond P. Cox		9/21/72 7:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE		B. COUNTY	
Johns Hopkins Hospital		Maryland		Balto Co	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Middle River		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER			
		42 Henderson Rd		21220	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9/9/17	55	Retired
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Nebraska	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Doc Cox		Bertie Hoffman		U.S.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
YES		217-07-6501		Son	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		1 hr.	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		6 hours	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) MYOCARDIAL INFARCTION		1 day	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 9/21 6:15AM 1972 to 9/21 7:15AM 1972, that (I) (we) last saw the deceased alive on 7:15 9/21 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
J. Raymond Delane		9/21/72			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
J. Raymond Delane		THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		9/25/72		HOLLY HILL	
24D. LOCATION (City, town, or county) (State)		24E. DATE 'REC'D' BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
BALTO. MD		SEP 25 1972		J. G. CONNELLY	
25A. DATE 'REC'D' BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
		J. G. CONNELLY		300 MACÉ	

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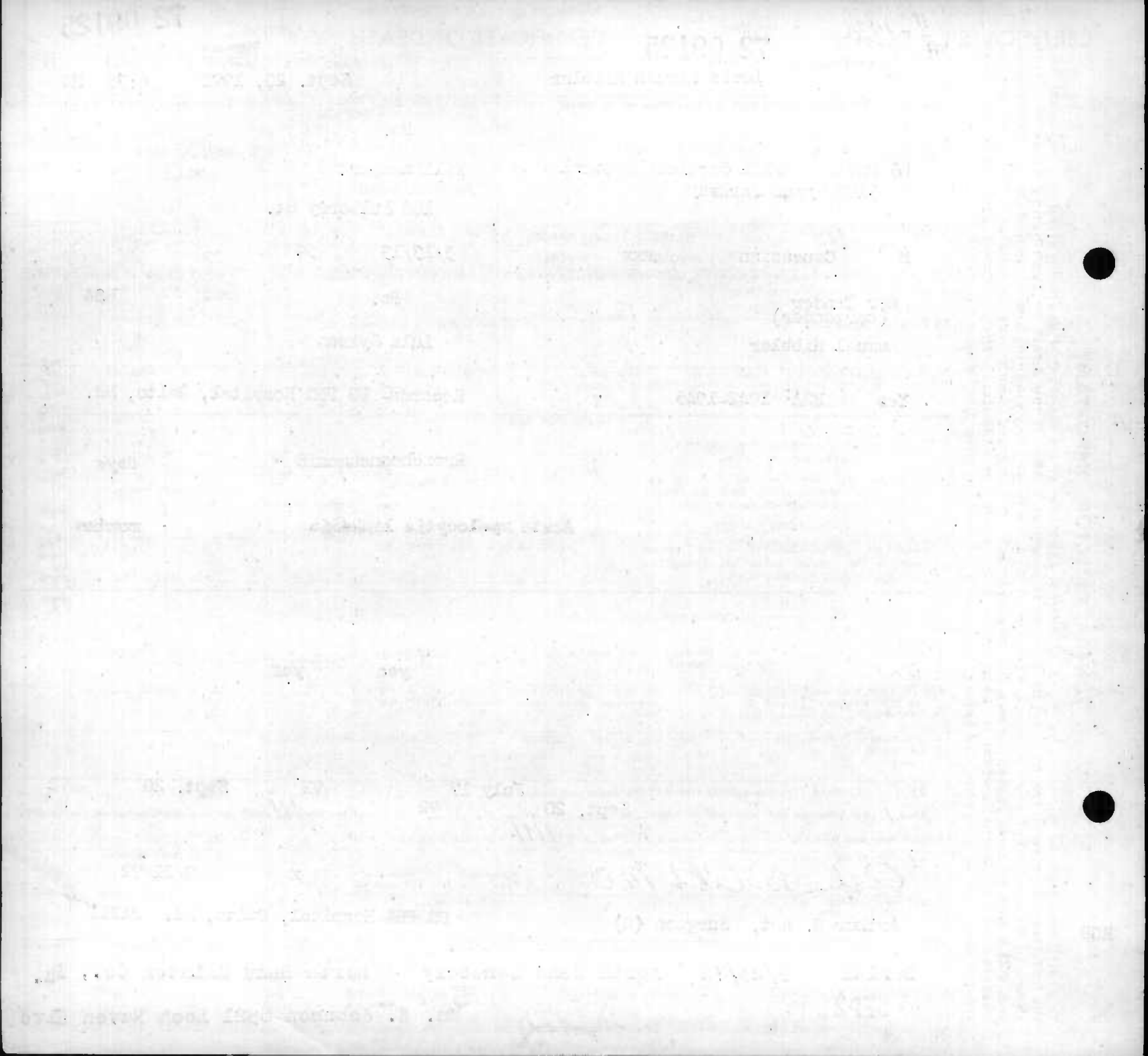
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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BALTIMORE CITY HEALTH DEPARTMENT				72 09125		REG. NO. 72 09125	
BIRTH NO. <u>4-146</u>		72 09125		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Lewis Martin Hibbler</b>				2. DATE AND HOUR OF DEATH <b>Sept. 20, 1972 6:35 PM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>US Public Health Service Hospital 3100 Wyman Parkway</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Pa.</b> B. COUNTY <b>V35</b>			
5. SEX <b>M</b>		6. RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/13/13</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bar Tender (bartender)</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Samuel Hibbler</b>				14. MOTHER'S MAIDEN NAME <b>Lula Sykes</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes USA 1942-1945</b>		16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT ADDRESS <b>Records- US PHS Hospital, Balto, Md.</b>			
18. <b>205.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Bronchopneumonia</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Acute myelocytic leukemia</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>months</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>July 17 1972</b> to <b>Sept. 20 1972</b> , that (I) (we) lost saw the deceased alive on <b>Sept. 20 1972</b> and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Arthur B. Abt, M.D.</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>9/21/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Arthur B. Abt, Surgeon (R)</b>				23D. ADDRESS <b>US PHS Hospital, Balto, Md. 21211</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/23/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>North Bend Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>North Bend Clinton Co., Pa.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 25 1972</b>		25B. NAME OF REGISTRAR <b>Andrew Johnson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Wm. E. Johnson 8521 Loch Raven Blvd</b>			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 09126

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>METTIE P. MOORE</b> <b>METTIE MOORE</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> September 23, 1972		Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Baltimore City Hospital (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year September 23, 1972		Hour 9:02 P. M.	
6. SEX Female		7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH MAR. 19, 1885		10. AGE (In years last birthday) 87		11. BIRTHPLACE (State or foreign country) ARKANSAS	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME -UNK-		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	
15. MOTHER'S MAIDEN NAME SARAH PAGE		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 431-01-0733	
18. INFORMANT MRS. EDW. W. CRUSSE		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Diabetes mellitus		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Marvin S. Platt</b> M.D. EXAMINER'S NAME (Type) <b>Marvin S. Platt, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> September 24, 1972					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/27/72		24C. NAME OF CEMETERY or CREMATORY ROSE LAWN	
24D. LOCATION (City, town, or county) (State) LITTLE ROCK, ARK.		25A. DATE REC'D BY HEALTH DEPT. SEP 25 1972		25B. NAME OF REGISTRAR A. J. [illegible]	
25C. FUNERAL DIRECTOR [illegible]		25D. ADDRESS [illegible]		25E. [illegible]	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-455		72 09127		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09127	
BIRTH NO.				CERTIFICATE OF DEATH		STATE OF MARYLAND - DEATH	
1. NAME OF DECEASED (Type or Print) <b>GERTRUDE SHULMAN</b>				2. DATE AND HOUR OF DEATH <b>9/20/72 12:28 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>LEVINDALE Hebrew Geriatric Center + Hospital</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2720</b>			
				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>3800 GLENGYLE AVENUE #21215</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-08-94</b>	9. AGE (in years last birthday) <b>78</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED PROPRIETOR</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>RESTAURANT</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ISAAC KAPLAN</b>				14. MOTHER'S MAIDEN NAME <b>LEAH ?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MRS. MINNIE KESSLER, 3800 GLENGYLE AVE. #21215</b>			
18. <b>174X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>SEPTICEMIA</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>DECURBITUS ULCERS</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>RADICAL mastectomy bilat.</b> (C)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>a week</b> <b>16 weeks</b> <b>6 yrs.</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1/6</b> 19 <b>70</b> to <b>9/20</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>9/20</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Elsa R. Merani, MD</b>				23B. DATE SIGNED <b>9/20/72</b>		23C. PHYSICIAN'S NAME (Type) <b>ELSA R. MERANI, MD</b>	
23D. ADDRESS <b>Levindale</b>				23E. FUNERAL DIRECTOR <b>SOLE LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>9/22/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>FRIEDEL MARYLAND LODGE</b>		24D. LOCATION (City, town, or county) (State) <b>ROSEDALE, MARYLAND</b>	
25A. DATE RECEIVED BY HEALTH DEPT. <b>SEP 25 1972</b>		25B. NAME OF REGISTRAR <b>Levindale</b>		25C. FUNERAL DIRECTOR <b>SOLE LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>			

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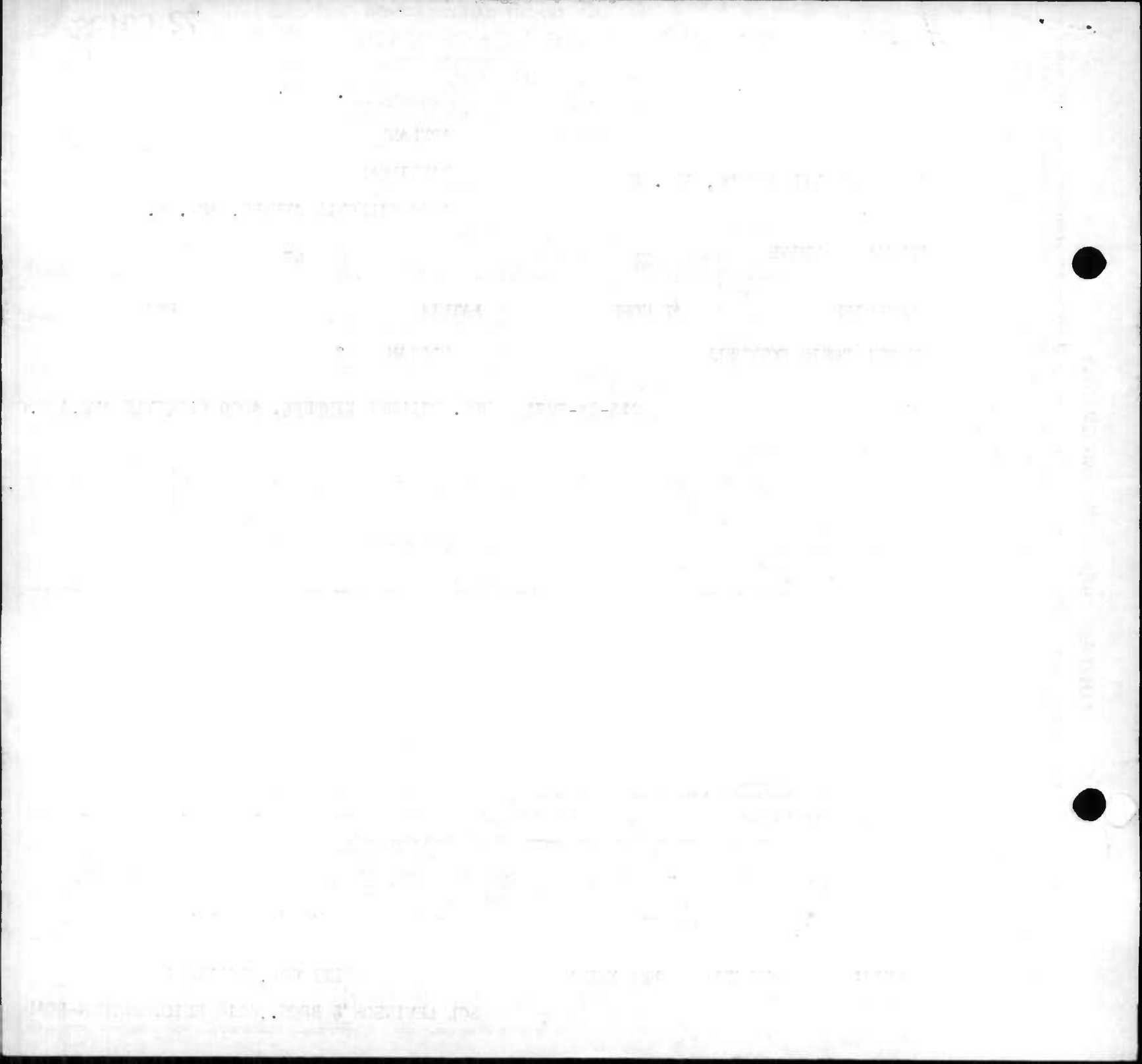
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

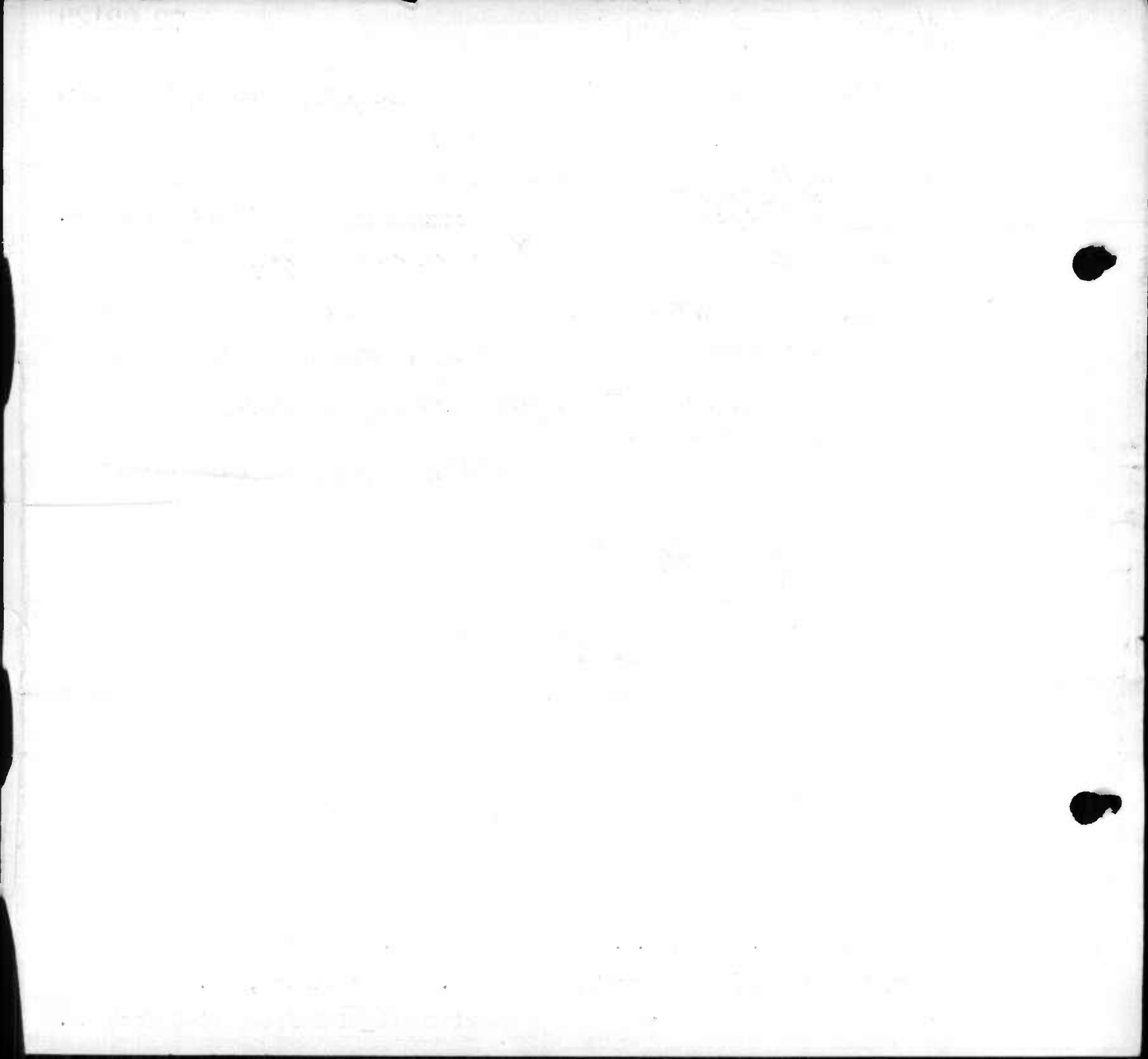
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 09128</u>
72 09128 CERTIFICATE OF DEATH				STATE OF MARYLAND, DEPT.
BIRTH NO. <u>A-136</u>		1. NAME OF DECEASED (Type or Print) <u>Bessie Gottself Apter</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <u>September 19, 1972 11:45 p.m.</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>4000 GLENGYLE AVENUE, APT. C</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2720</u>		
5. SEX <u>FEMALE</u>		6. RACE <u>WHITE</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>67</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>LATVIA</u>		
10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>SAMUEL RUBIN GOTTHELF</u>		14. MOTHER'S MAIDEN NAME <u>MIRIAM ?</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-28-7971</u>		
17. INFORMANT <u>MRS. MILDRED KIMBERK, 4000 GLENGYLE AVE. APT. C</u>		ADDRESS		
18. <u>I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Carcinoma of the Gall Bladder</u> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>15726172</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Jaundice</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>pathology Spec - yes</u> (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>May 26</u> 19 <u>72</u> to <u>present</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>September 17</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour end from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Jay N Karpa</u>		23B. DATE SIGNED <u>9/20/72</u>		23C. PHYSICIAN'S NAME (Type) <u>JAY N KARPA</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>9/27/72</u>		24C. NAME of CEMETERY or CREMATORY <u>OIEL YAKOV</u>
24D. LOCATION <u>BALTIMORE, MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 25 1972</u>		
25B. NAME OF REGISTRAR <u>Andrey Khoroskov</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</u>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09129	
CERTIFICATE OF DEATH				72 09129	
STATE OF MARYLAND - DEMO				REG. NO.	
BIRTH NO. N-000		72 09129		72 09129	
1. NAME OF DECEASED (Type or Print) <b>ETHEL Lucille New</b>			2. DATE AND HOUR OF DEATH <b>Sept. 20th 1972 6:35 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>Keswick Home for Incurables</b> ADDRESS OR LOCATION <b>700 W. 40th Street BALTO, Md. 21211</b>			4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) A. STATE <b>MD</b> B. COUNTY <b>905</b>		
5. SEX <b>FEMALE</b>			6. RACE <b>White</b>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>10-8-1897</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sales Lady</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>W.T. GRANT CO.</b>		
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Louis W. New</b>			14. MOTHER'S MAIDEN NAME <b>EMMA FRANCES CAMERON</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>220-24-4128</b>		
17. INFORMANT <b>Keswick Files</b>			ADDRESS		
18. <b>412.414.250.9</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Arteriosclerotic CVD</b> (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>DIABETES Mellitus</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>many yrs</b> <b>3 wks</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>DIABETES Mellitus</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>JUNE 1970</b> to <b>20 Sept 1972</b> that (I) (we) last saw the deceased alive on <b>20 Sept 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Harold P. Biehl M.D.</b>			23B. DATE SIGNED <b>21 Sept 72</b>		
23C. PHYSICIAN'S NAME (Type) <b>HAROLD P. BIEHL, M.D.</b>			23D. ADDRESS <b>700 W. 40th Street</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/23/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Lorraine Park Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 25 1972</b>		25B. NAME OF REGISTRAR <b>Audrey Jackson</b>		25C. FUNERAL DIRECTOR <b>MITCHELL WIEDEFELD</b>	
25D. ADDRESS <b>6500 York Rd.</b>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-536 BIRTH NO.		72.09130 BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72.09130 STATE OF MARYLAND-DEME	
1. NAME OF DECEASED (Type or Print) ANDERSEN, JOHAN			2. DATE AND HOUR OF DEATH SEPTEMBER 20, 1972 6:10P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3234 CLIFTON AVE		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/11/1867	9. AGE (In years last birthday) 105	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Estimator			10B. KIND OF BUSINESS OR INDUSTRY Steel		11. BIRTHPLACE (State or foreign country) NORWAY
12. CITIZEN OF WHAT COUNTRY? U S CITIZEN			13. FATHER'S NAME JULUIS ANDERSEN		
14. MOTHER'S MAIDEN NAME MARY MALON			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 218 102345			17. INFORMANT ST AGNES RECORDS BALTO MD 21229		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Intertrochanteric Fr of lt hip			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF Respiratory failure (B) Insuspirated pulmonary secretion (C) possible pulmonary emboli.		
19A. DATE OF OPERATION sep. 12/72			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fair		
20A. AUTOPSY? (Yes or No) No			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21D. TIME OF INJURY (APPROX.) sep. 10. 1972			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) at Baltimore city 3234 Clifton Ave 21F. HOW DID INJURY OCCUR? patient fell at home.		
22. I certify that (X) (this hospital) attended the deceased from SEPTEMBER 10 19 72 to SEPTEMBER 20 19 72, that (X) (we) last saw the deceased alive on SEPTEMBER 20 19 72 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Tse-shiung Wu			23B. DATE SIGNED 9/20/72		
23C. PHYSICIAN'S NAME (Type) Tse-shiung Wu			23D. ADDRESS St. Agnes Hospital, Baltimore		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 9/23/72		
24C. NAME OF CEMETERY OR CREMATORY Lorraine			24D. LOCATION (City, town, or county) (State) Woodlawn Md		
25A. DATE REC'D BY HEALTH DEPT. SEP 25 1972			25B. NAME OF REGISTRAR Mitchell Wiedel		
25C. FUNERAL DIRECTOR 6500 York Rd			25D. ADDRESS		

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SEPTEMBER 22, 1957

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SEPTEMBER 22, 1957

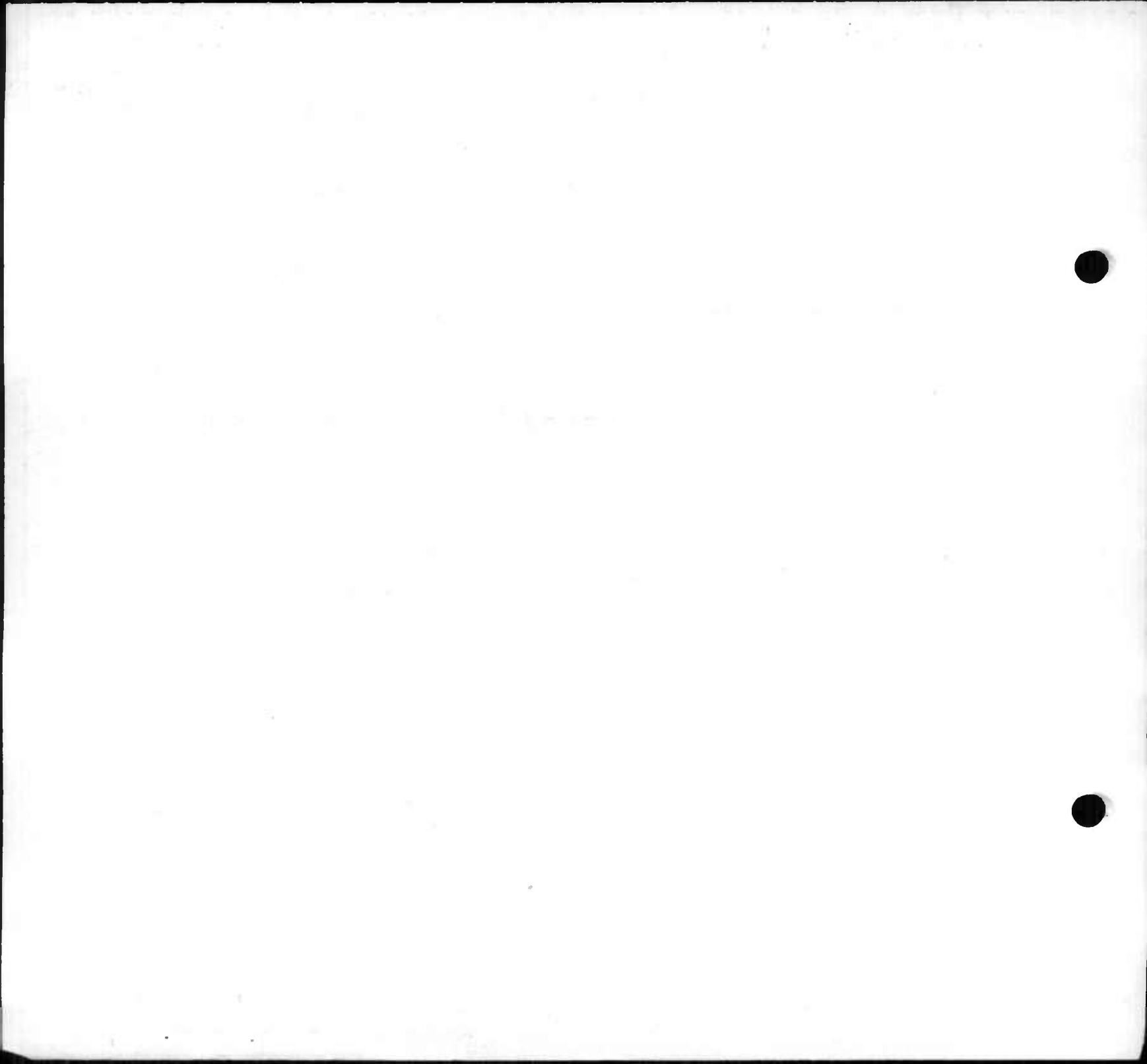
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72 09131 STATE OF MARYLAND-DEME	
1. NAME OF DECEASED (Type or Print) <b>CHARLES WOHRNA</b>		2. DATE AND HOUR OF DEATH <b>9/22/72 13:48 AM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNIVERSITY OF MARYLAND HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTO</b>			
5. SEX <b>M</b> 6. RACE <b>C W</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-14-96</b>		9. AGE (In years last birthday) <b>76</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Glass Artist</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>CHARLES WOHRNA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES</b>		6. SOCIAL SECURITY NO. <b>214-03-3508A</b>		17. INFORMANT <b>Miss Margaret Wohrna</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>207.91</b> <b>CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) <b>INFECTION</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>LEUKEMIA</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>MOMENTS</b> <b>5 days</b> <b>3 months</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>ANEMIA, AGE</b>					
19A. DATE OF OPERATION <b>NONE</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Foot) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Sept 4 19 72</b> to <b>Sept 22 19 72</b> that (I) (we) last saw the deceased alive on <b>Sept 22 19 72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Thomas E. Murphy Jr MD</b>		23B. DATE SIGNED <b>9/22/72</b>		23C. PHYSICIAN'S NAME (Type) <b>Thomas E. Murphy Jr</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/25/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Lake View</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 25 1972</b>		25B. NAME OF REGISTRAR <b>Alvin Whiston</b>		25C. FUNERAL DIRECTOR <b>Leonard J Ruck Inc. Baltimore, Md</b>	





# FUNERAL DIRECTOR: IMPORTANT

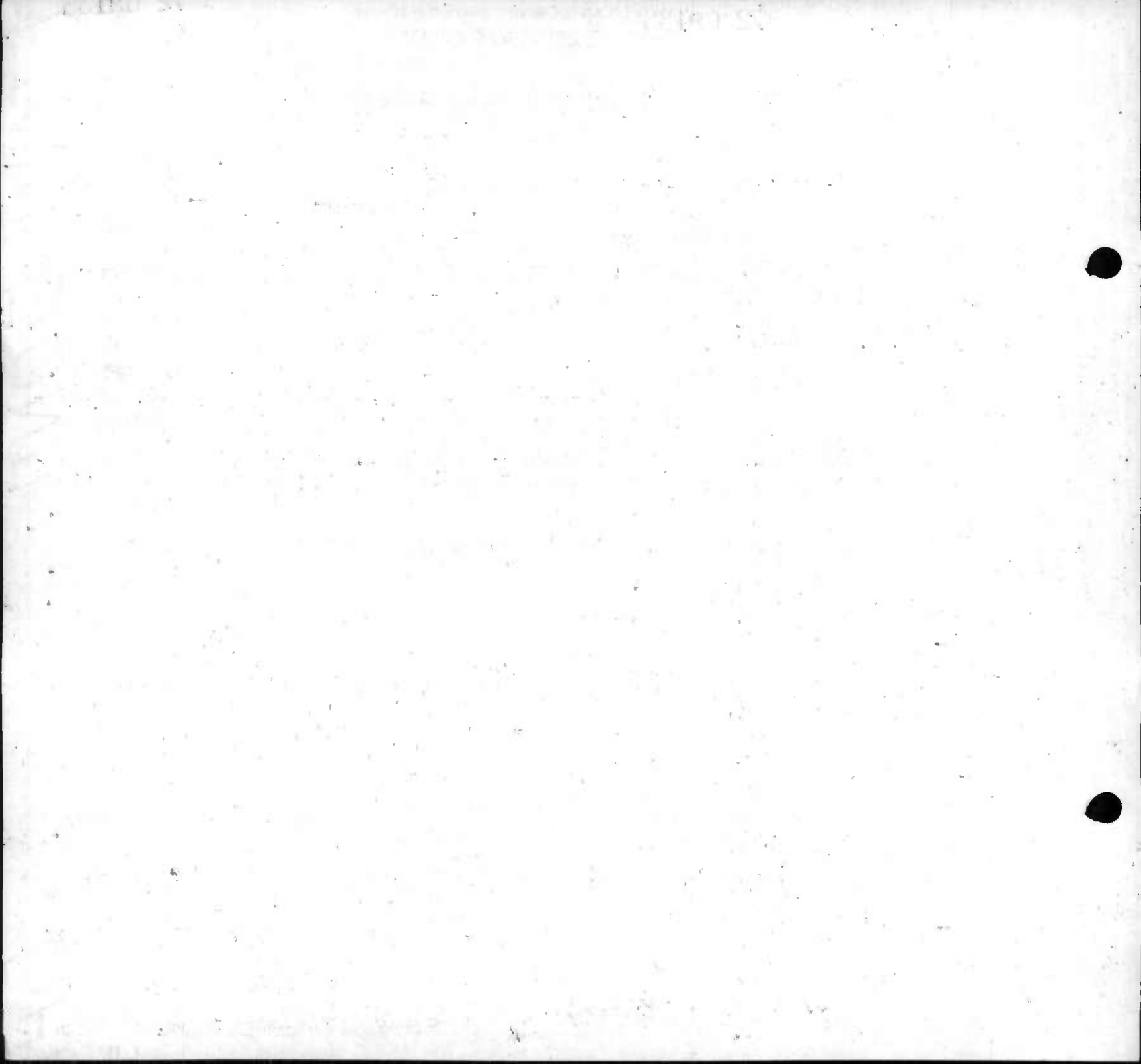
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09132	
L-520 72 09132				STATE OF MARYLAND	
BIRTH NO.				DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>GEORGE W. LANGE</b>				2. DATE AND HOUR OF DEATH <b>9. 21. 72. 1-30 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>5300</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>48 Maryland General Hospital</b>				C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>3035 Linwood Ave</b>	
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT 01. 95</b>	9. AGE (In years last birthday) <b>76</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Transit Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Unknown Lange</b>				14. MOTHER'S MARDEN NAME <b>Unknown</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <b>Yes W W I</b>		16. SOCIAL SECURITY NO. <b>213-10-1415</b>		17. INFORMANT <b>Mrs. Madeline Lange</b> ADDRESS <b>Same</b>	
18. <b>189.2</b> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Uraemia.</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Renal Failure</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of Prostate &amp; renal obstruction</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>19.6.72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Rt Ureteral Obstruction</b>		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>(this hospital)</b> attended the deceased from <b>9. 4. 1972</b> to <b>9. 21. 1972</b> that (I) (we) last saw the deceased alive on <b>9. 21. 1972</b> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>[Signature] M.D.</b>				23B. DATE SIGNED <b>9. 21. 72.</b>	
23C. PHYSICIAN'S NAME (Type) <b>AHSAN S. KHAN M.D.</b>				23D. ADDRESS <b>Maryland General Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/25/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Moreland Memorial Park Cem.</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>Almy H. Hinton</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. 5305 Harford Rd. 21211</b>	

CO

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

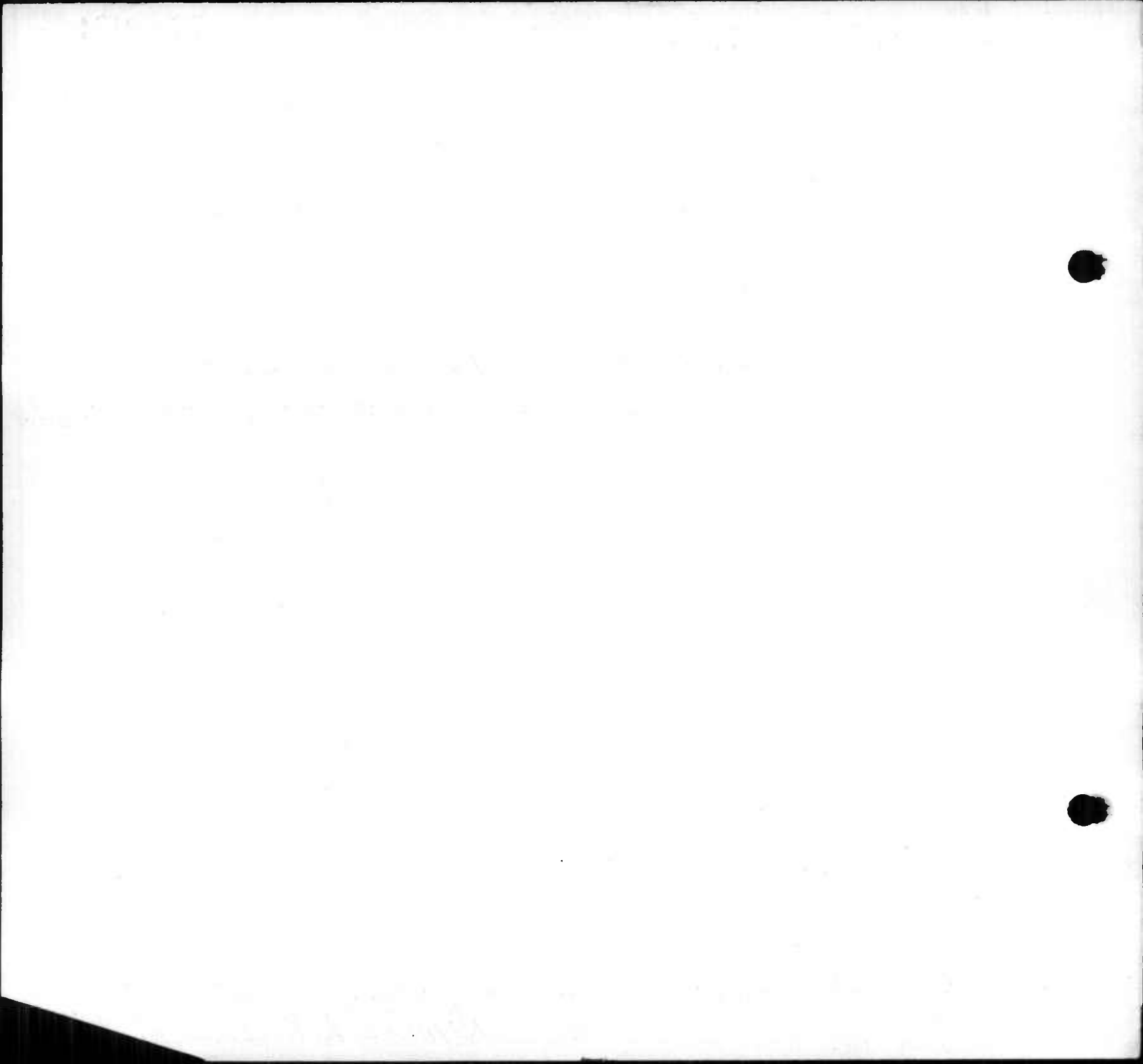
BALTIMORE CITY HEALTH DEPARTMENT				72 09133		72 09133	
CERTIFICATE OF DEATH				REG. NO.		STATE OF MARYLAND-DETH	
BIRTH NO. <span style="font-size: 1.5em;">K-460</span>				1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Blanche M. Keller</span>			
2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">9-8-72</span>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">4129 Doris Avenue Baltimore 21225</span>			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span>		B. COUNTY <span style="font-size: 1.2em;">2544</span>		C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <span style="font-size: 1.2em;">4129 Doris Avenue</span>				5. SEX <span style="font-size: 1.2em;">Female</span>			
6. RACE <span style="font-size: 1.2em;">White</span>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <span style="font-size: 1.2em;">3/18/1904</span>		9. AGE (In years last birthday) <span style="font-size: 1.2em;">68</span>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Housewife</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Pennsylvania</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">R. G. Mc Ilwain</span>				14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Emma Staller</span>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, No or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">NO</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">220-30-1897</span>		17. INFORMANT <span style="font-size: 1.2em;">George R. Keller</span>			
				ADDRESS <span style="font-size: 1.2em;">4129 Doris Ave. 21225</span>			
18. <span style="font-size: 1.2em;">199.0 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH <span style="font-size: 1.2em;">Terminal</span> <span style="font-size: 1.2em;">Metastatic Carcinoma, breast</span> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">Several months</span>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <span style="font-size: 1.2em;">12/10/72</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <span style="font-size: 1.2em;">fair</span>		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">No</span>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) lost saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <span style="font-size: 1.2em;">Paul J. Chang</span>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <span style="font-size: 1.2em;">9/9/72</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Paul J. Chang, MD</span>				23D. ADDRESS <span style="font-size: 1.2em;">801 Crain Hwy SE, Glen Burnie, Md. 2106</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">9/11/72</span>		24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Cedar Hill</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Glen Burnie Maryland</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">SEP 25 1972</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Audrey Johnston</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">McCully</span>			
				ADDRESS <span style="font-size: 1.2em;">237 Patapsco Ave. 21225</span>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

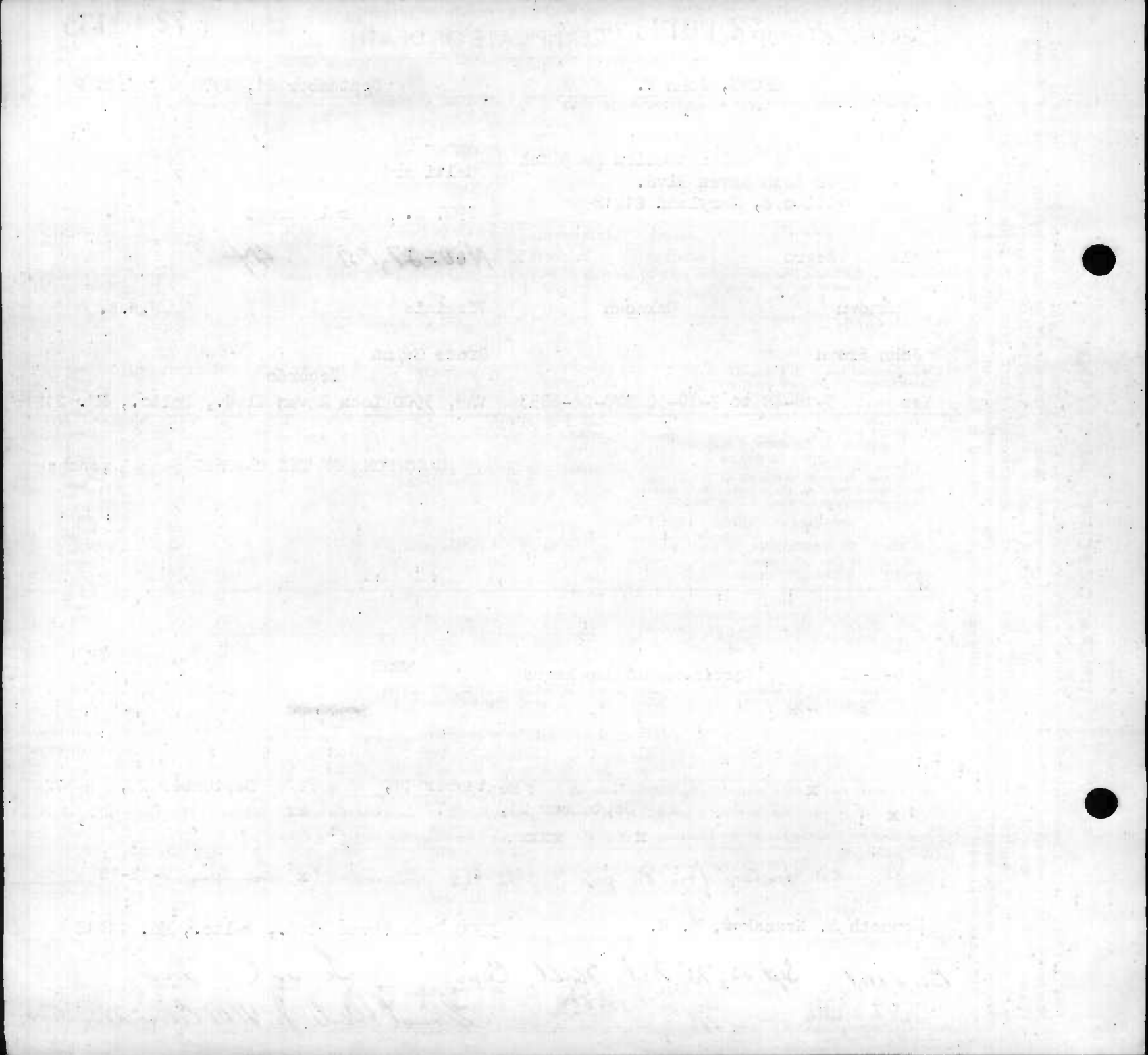
W-256		72 09134		BALTIMORE CITY HEALTH DEPARTMENT		72 09134	
BIRTH NO.		72 09134		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>WIESSNER CATHERINE I.</b>				2. DATE AND HOUR OF DEATH <b>9/24/72 6:30 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>48 Maryland General Hosp. 827 Linden Ave 21201 Pop. Hill</b>				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>48 Maryland General Hosp.</b>				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>F</b> 6. RACE <b>W</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>7/1/11</b>		9. AGE (In years last birthday) <b>61</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>CHRISTIAN BEASCH</b>				14. MOTHER'S MAIDEN NAME <b>FLORENCE LEWIS</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>212-09-1049</b>		17. INFORMANT <b>MR. Wm. WIESSNER</b> ADDRESS <b>645 S. LAKEWOOD AVE</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Cardiorespiratory arrest</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Tesmer's Id. (cancer)</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>1 yr</b> (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>9/24/72 6:30 PM</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>9/18</b> to <b>9/24</b> 19 <b>72</b> and that (I) (we) last saw the deceased alive on <b>9/24</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>J. G. H. M.D.</b>				23B. DATE SIGNED <b>9/24/72</b>		23C. PHYSICIAN'S NAME (Type) <b>J. G. H. M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/27/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>St. Evangelical Church Cem.</b>		24D. LOCATION (City, town, or county) <b>BALTIMORE</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 25 1972</b>				25B. NAME OF REGISTRAR <b>Raymond L. Kaczorowski</b>		25C. FUNERAL DIRECTOR <b>Raymond L. Kaczorowski</b>	



# FUNERAL DIRECTOR: IMPORTANT

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B-650		72 09135		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09135	
BIRTH NO.				STATE OF MARYLAND-DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
BROWN, John W.				September 21, 1972 2:30 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
Veterans Administration Hospital				Maryland			
3900 Loch Raven Blvd.				C. CITY OR TOWN D. INSIDE CITY LIMITS?			
Baltimore, Maryland 21218				Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER				2907 E. Federal Street			
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
Male		Negro		WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		November 27, 1917 44	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Unknown		Unknown		Virginia		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
John Brown				Grace Swann			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
Yes				3-18-48 to 3-19-52		Records	
				220-24-6853		VAH, 3900 Loch Raven Blvd., Balto., Md. 21218	
18. 150 X I				CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				CARCINOMA OF THE ESOPHAGUS 3 months			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
8-2-72		Carcinoma of Esophagus		NONE			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (he) (this hospital) attended the deceased from September 11, 1972 to September 21, 1972, that (he) (we) last saw the deceased alive on September 21, 1972 and that in (our) (our) applan death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Donald Hooker M. D. for				9-22-72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Kenneth A. Krazakow, M. D.				3900 Loch Raven Blvd., Balto., Md. 21218			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		Sept. 25, 72		Mt. Zeth Cem.		James C. Tho	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
SEP 25 1972		Lindsey M. H. H.		Samuel W. H. Jr.		4101 Edmondson Ave.	





**FUNERAL DIRECTOR: IMPORTANT**

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 09136</u>																																								
72 09136 CERTIFICATE OF DEATH				STATE OF MARYLAND-DEMH																																								
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>MOORE, OPHELIA</u>		2. DATE AND HOUR OF DEATH <u>9-22-72</u> <u>6:00</u> P.M.																																								
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Johns Hopkins Hosp.</u> <u>BALTIMORE, MD 21205</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1007 N. CENTRAL AVE</u>																																										
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-5-05</u>	9. AGE (In years last birthday) <u>67</u> yo.																																								
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE KEEPING</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)																																								
13. FATHER'S NAME <u>DALLAS PRINGLE</u>		14. MOTHER'S MAIDEN NAME <u>MARY JONES</u>																																										
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS																																								
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="2">18. CAUSE OF DEATH</th> <th>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</th> </tr> </thead> <tbody> <tr> <td colspan="2">DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Respiratory arrest</u></td> <td><u>1/2 hr</u></td> </tr> <tr> <td colspan="2">ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>? Pulmonary Embolus from thrombophle.</u></td> <td><u>1/2 hr</u></td> </tr> <tr> <td colspan="2">(C) <u>Severe CHF 2° to MHD</u></td> <td><u>3 weeks</u></td> </tr> </tbody> </table>					18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Respiratory arrest</u>		<u>1/2 hr</u>	ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>? Pulmonary Embolus from thrombophle.</u>		<u>1/2 hr</u>	(C) <u>Severe CHF 2° to MHD</u>		<u>3 weeks</u>																												
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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 09137

BIRTH NO.

STATE OF MARYLAND-DEME

1. NAME OF DECEASED (Type or Print) <b>Martin Gross</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <b>9</b> Day <b>22</b> Year <b>72</b> Hour <b>M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>33 Johns Hopkins Hospital</b>		3. DATE PRONOUNCED DEAD Month <b>9</b> Day <b>22</b> Year <b>72</b> Hour <b>5:55 p.</b>	
6. SEX <b>male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>7-21-41</b>		10. AGE (In years last birthday) <b>31</b>	
11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Frank Gross</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME <b>Margaret Johnson</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO. <b>220-36-2513</b>		18. INFORMANT <b>Margaret Walker</b>	
19. CAUSE OF DEATH <b>Gunshot wound of chest</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>1000 block of N. Chester Street</b>			
22D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY (APPROX.) <b>9 22 72 5:30 p.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? <b>Subject was shot</b>			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Marvin S. Platt</b>		M.D.	
EXAMINER'S NAME (Type) <b>Marvin S. Platt, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/27/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Abtutes mem. PK.</b>		24D. LOCATION (City, town, or county) (State) <b>Abtutes, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 25 1972</b>		25B. NAME OF REGISTRAR <b>Edw. H. Brown</b>	
25C. FUNERAL DIRECTOR <b>Joseph 36. Rock</b>		ADDRESS <b>8130 N. Central</b>	

75 10137

75 10137

James M. Smith  
James M. Smith  
James M. Smith

7-21/44  
8-1-44

No

James M. Smith

100

100 10137

100 10137

100 10137

100 10137

James M. Smith  
James M. Smith  
James M. Smith

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		72 09138		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09138	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
SAUTER MARGARET, A.				9-22-72 4:00 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION NORTH CHARLES GEN. HOSP.				A. STATE MARYLAND			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				B. COUNTY BALTO.			
				C. CITY OR TOWN BALTO.			
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER 6195 MASON ST. #21224			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-11-77	9. AGE (In years last birthday) 95	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		11. BIRTHPLACE (State or foreign country) MARYLAND
					12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME ANDREW HARNER			14. MOTHER'S MAIDEN NAME RACHELL STEINER				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. NONE		17. INFORMANT MARGARET A. GALLAGHER		ADDRESS SAME
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) I RENAL FAILURE DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) NEPHROSCLEROSIS & LT E DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). ASHD w/ MYOCARDIAL ISCHEMIA				yrs ym ym			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 9-17-72 to 9-22-72 that (I) (we) last saw the deceased alive on 9-22-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Ruperto Manankil MD				23B. DATE SIGNED 9-22-72		23C. PHYSICIAN'S NAME (Type) RUPERTO MANANKIL MD	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-25-72		24C. NAME OF CEMETERY OR CREMATORY PARKWOOD CEM.		24D. LOCATION (City, town, or county) (State) BALTO. CO., M.D.	
25A. DATE REC'D BY HEALTH DEPT. SEP 25 1972		25B. NAME OF REGISTRAR Audrey Ingham		25C. FUNERAL DIRECTOR Charles S. Guler 6224 EASTERN AVE. BALTO. 21224, M.D.			

Black Charles Gen. Hosp.

Female White

x

ANDREW HAWK  
RETIRED  
HOUSE WORK

NC — NC

MARYLAND

BALTO.

~~WISCONSIN~~ 27-11-12

9-11-12

92

RACHEL STEIN

INTEREST & CALORIC

BURIAL 4-22-22 PARKWOOD CEM

John A. Jones

3310 TAYLOR AVE. BALTO.

2224 EASTERN AVE. BALTO.



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 09139

BIRTH NO.

STATE OF MARYLAND-DEATH

1. NAME OF DECEASED  
(Type or Print)

Flint Hamlet

2. DATE OF DEATH Known ☒ Estimated ☐ Month Day Year Hour  
9 18 72 M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Johns Hopkins Hospital

3. DATE PRONOUNCED DEAD Month Day Year Hour  
9 18 72 2:35 a. M.5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE B. COUNTY

Md.

806

6. SEX

male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

2/8/28

10. AGE (In years last birthday)

44

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

1801 N. Register Street

11. BIRTHPLACE (State or foreign country)

ROXBORO N.C. PEARSON CO.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

CALVIN HAMLETT

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

CONSTRUCTION LABORER

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

MARY THROPE

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

17. SOCIAL SECURITY NO.

243-36-6366

18. INFORMANT

ADDRESS

GATTIS STREET 1036 W. FAYETTE ST. BALT. MD.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Ruptured heart

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

Blunt trauma to chest

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)  
yes22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  
Apt.22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

834 E. Chase Street (3rd floor)

22D. TIME (Month) (Day) (Year) (Hour) (Approx.)  
9 18 72 1:55 a. m.

22E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

Subject jumped from window. 1001

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Peter Lipkovic, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/18/72

24A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

9/25/72

24C. NAME of CEMETERY or CREMATORY

CLEGGS CHAPEL CEM.

24D. LOCATION (City, town, or county) (State)

ROXBORO, NORTH CAROLINA

25A. DATE REC'D BY HEALTH DEPT.

SEP 25 1972

25B. NAME OF REGISTRAR

William J. Spicer

25C. FUNERAL DIRECTOR

ADDRESS

WILLIAM J. SPICER 1639 N. BROADWAY BALT. MD.

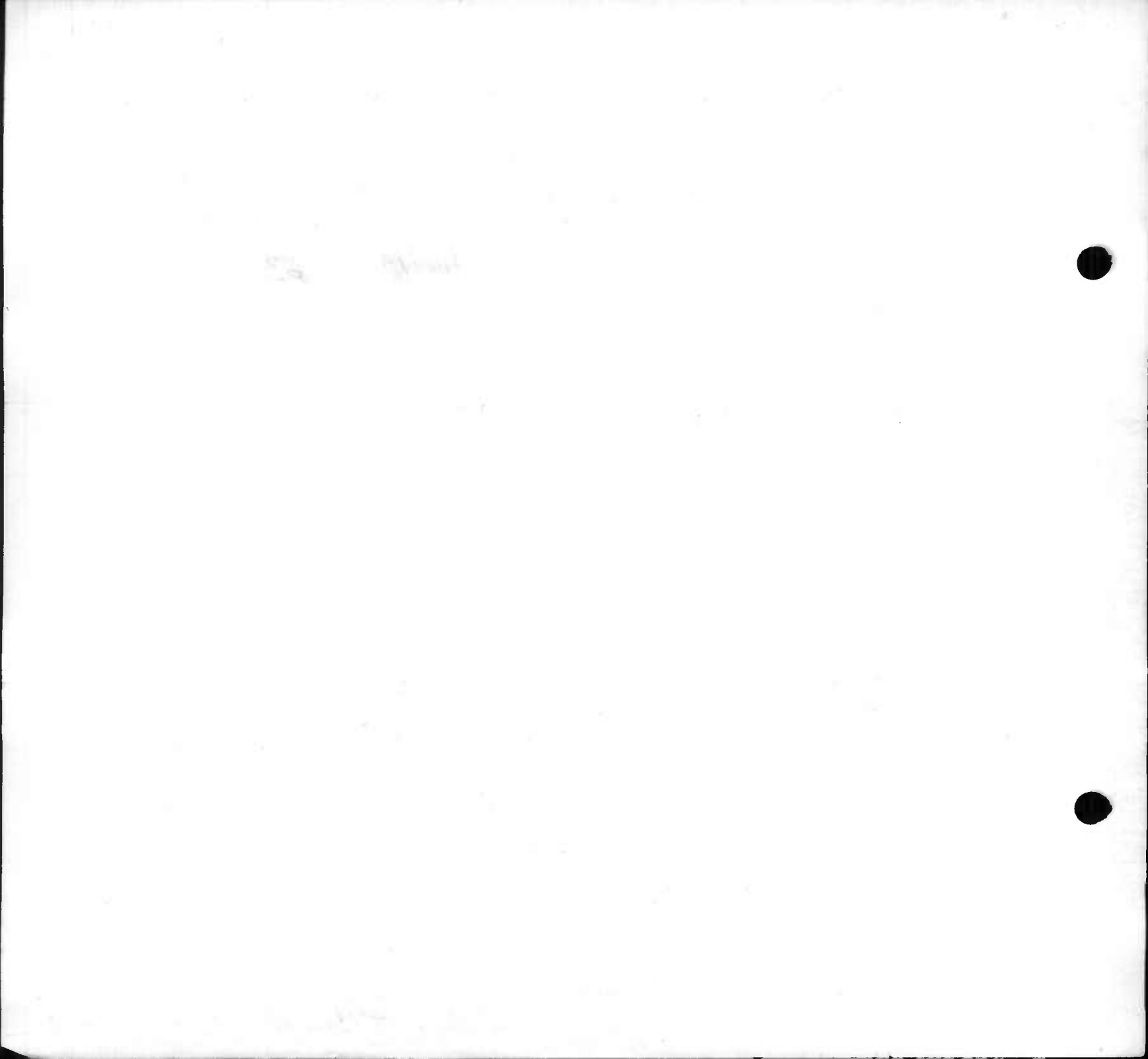
*Signature*



FUNERAL DIRECTOR: IMPORTANT

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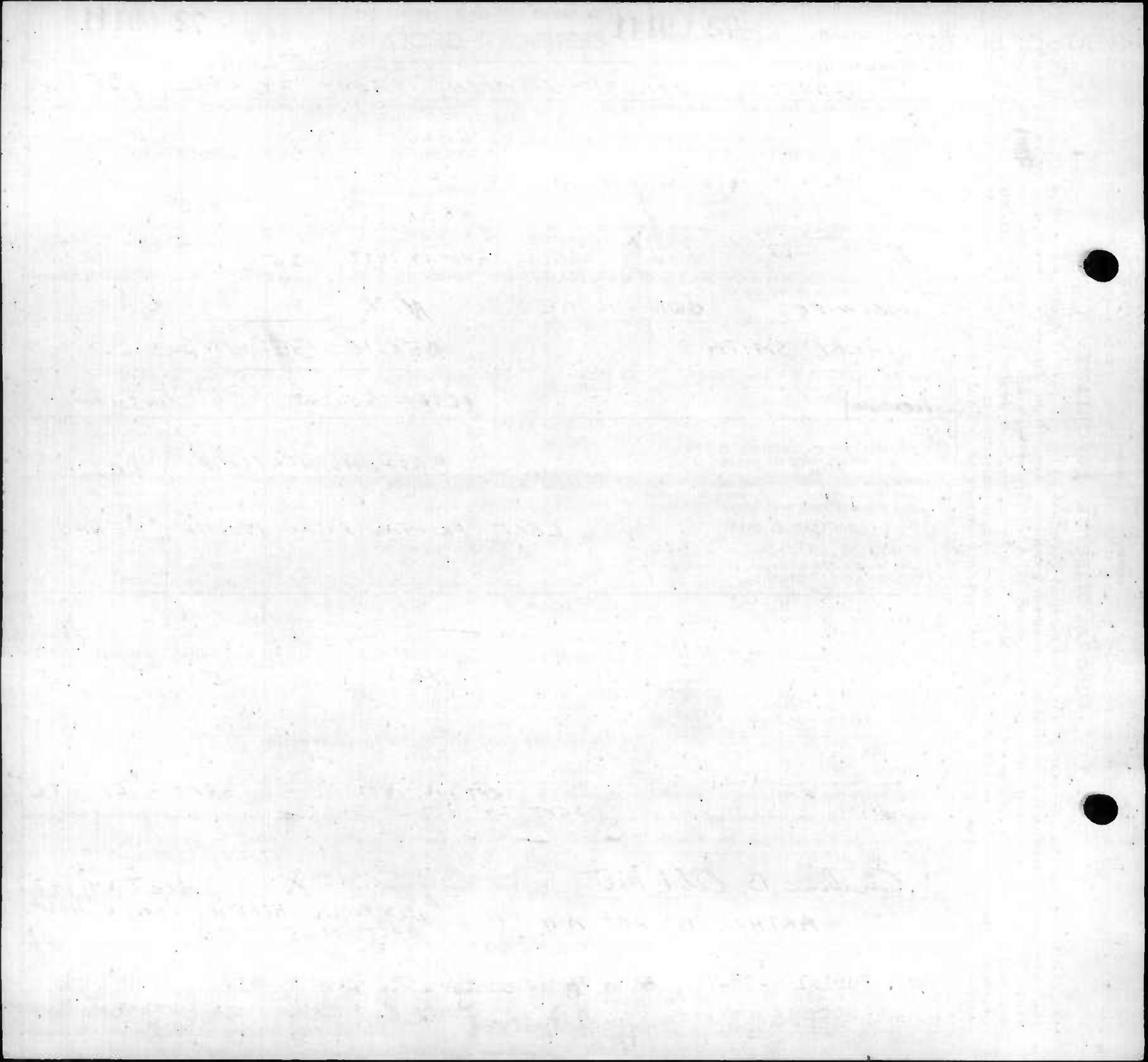
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 09140	
1. NAME OF DECEASED (Type or Print) <u>Holland, Margaret W</u>		2. DATE AND HOUR OF DEATH <u>9/12/72 8:40 pm</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>38 University of Maryland Hospital Baltimore MD.</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>♀</u>		6. RACE <u>Black</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>12/12/1908</u>		9. AGE (In years last birthday) <u>63</u>		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY		13. FATHER'S NAME <u>not known</u>		14. MOTHER'S MAIDEN NAME <u>not known</u>	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-145-323</u>		17. INFORMANT <u>Chart</u>	
18. CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
(A) IMMEDIATE CAUSE <u>Uremia</u> DUE TO, OR AS A CONSEQUENCE OF:		(B) <u>Arteriosclerotic Renal Disease</u> DUE TO, OR AS A CONSEQUENCE OF:		(C) <u>—</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>None</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <u>None</u>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (H) (this hospital) attended the deceased from <u>9/5</u> 19 <u>72</u> to <u>9/12</u> 19 <u>72</u> that (H) (we) last saw the deceased alive on <u>9/12</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Louis C. Kandl MD</u>		23B. DATE SIGNED <u>9/12/72</u>		23C. PHYSICIAN'S NAME (Type) <u>LOUIS C. KANDL MD</u>	
23D. ADDRESS <u>UNIV. HOSP.</u>		24A. BURIAL-CREATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>9/18/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Calvary Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>D.P. County, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 25 1972</u>		25B. NAME OF REGISTRAR <u>Frederick T. Hinton</u>		25C. FUNERAL DIRECTOR <u>Frederick T. Hinton</u>	



# FUNERAL DIRECTOR: IMPORTANT

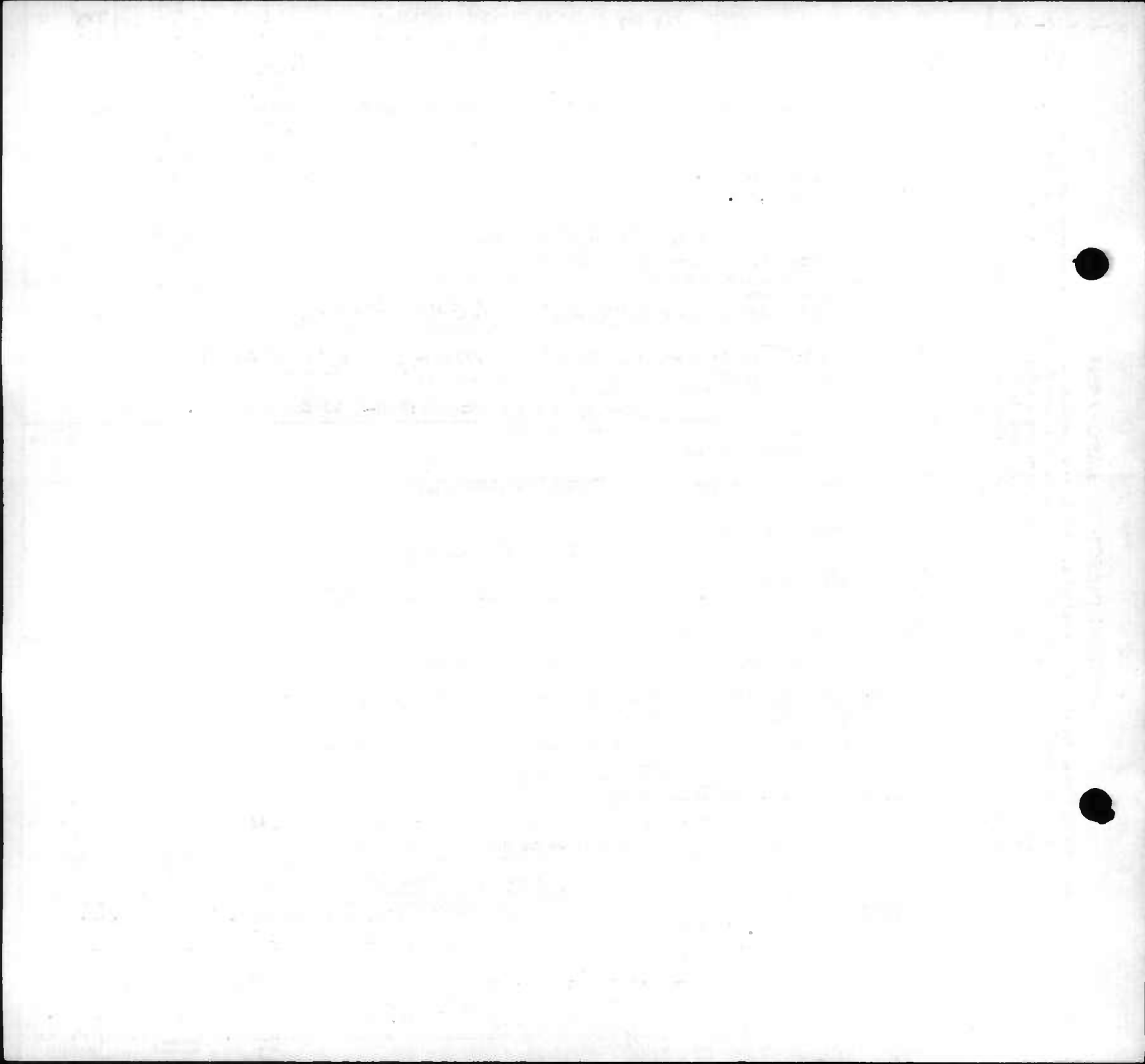
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09141	
G-320 72 09141				CERTIFICATE OF DEATH	
BIRTH NO.		STATE OF MARYLAND-DEM			
1. NAME OF DECEASED (Type or Print) <b>GOUTOS, DOROTHY SMITH</b>		2. DATE AND HOUR OF DEATH <b>SEPT 24, 1972 7:25 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>DEL.</b> B. COUNTY <b>V07</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>U.S. PUBLIC HEALTH SERVICE HOSP</b>		C. CITY OR TOWN <b>CLAYMONT</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>831 MARVEL AVE</b>					
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG 18, 1937</b>	9. AGE (In years last birthday) <b>35</b>	10. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>N.Y.</b>	
13. FATHER'S NAME <b>HARRY SMITH</b>		14. MOTHER'S MAIDEN NAME <b>BESSIE SEBRING</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT <b>PETER GOUTOS (SAME) HUSBAND</b>	
18. CAUSE OF DEATH <b>191X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>BRONCHOPNEUMONIA</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>LEFT FRONTAL ASTROCYTOMA</b> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <b>21</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>YES</b> 20A. AUTOPSY? (Yes or No) <b>YES</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>DAYS</b> <b>YEARS</b>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>he</del> (this hospital) attended the deceased from <b>SEPT 12, 1972</b> 19 to <b>SEPT 24, 1972</b> , that <del>he</del> (we) lost saw the deceased alive on <b>SEPT 24, 1972</b> and that in <del>our</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <del>we</del> (did) (did not) view the body after death.					
23A. SIGNATURE <b>Arthur B. Abt, M.D.</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>Sept 24, 1972</b>	
23C. PHYSICIAN'S NAME (Type) <b>ARTHUR B. ABT, M.D.</b>		23D. ADDRESS <b>U.S PUBLIC HEALTH SERVICE HOSP BALTIMORE, MD.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Rem. Burial</b>		24B. DATE <b>9-28-72</b>		24C. NAME of CEMETERY or CREMATORY <b>Queensbury, New York</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 25 1972</b>		25B. NAME OF REGISTRAR <b>Sidney H. Hinton</b>		25C. FUNERAL DIRECTOR <b>Henry W. Jenkins Sons 4905 York Rd. Baltimore, Md. 21212</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09142	
M-532 72 09142				CERTIFICATE OF DEATH	
BIRTH NO.				STATE OF MARYLAND-DIRECTOR	
1. NAME OF DECEASED (Type or Print) <i>Carol W. Montgomery</i>			2. DATE AND HOUR OF DEATH <i>9/24/72 8:15 A.M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Baltimore City Hospitals</i>			C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <i>4940 Eastern Ave. Baltimore, Md. 21224</i>			E. STREET AND NUMBER <i>7813 Ellenham Avenue 21204</i>		
5. SEX <i>Female</i>	6. RACE <i>Caucasian</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/30/20</i>	9. AGE (In years last birthday) <i>32</i>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>TEACHER AND LIBRARIAN</i>			11. BIRTHPLACE (State or foreign country) <i>NEW YORK</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>
13. FATHER'S NAME <i>DR. J. KENT WORTHINGTON</i>			14. MOTHER'S MAIDEN NAME <i>MARY W. SPENCER</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>			16. SOCIAL SECURITY NO. <i>604-16-4533</i>		17. INFORMANT <i>Records: BCH-4940 Eastern Ave. 21224</i>
18. <i>183.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Metastatic Ovarian Carcinoma</i> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <i>2/1</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <del>(the hospital)</del> attended the deceased from <i>9/24 1972</i> to <i>9/24 1972</i> that (I) <del>(last)</del> saw the deceased alive on <i>9/24 1972</i> and that in (my) <del>(my)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) <del>(did)</del> view the body after death.					
23A. SIGNATURE <i>Roland C. Einhorn, MD</i>				23B. DATE SIGNED <i>9/24/72</i>	
23C. PHYSICIAN'S NAME (Type) <i>Roland C. Einhorn, MD</i>				23D. ADDRESS <i>4940 Eastern Ave., Baltimore, Md. Baltimore City Hospitals</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Cremation</i>		24B. DATE <i>9-25-72</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Green Mount Crematory, Baltimore, Maryland</i>	
24D. LOCATION <i>Baltimore, Maryland</i>		24E. NAME OF REGISTRAR <i>Sidney W. Jenkins</i>		24F. FUNERAL DIRECTOR <i>Henry W. Jenkins Sons 4905 York Rd. Baltimore, Md. 21212</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 25 1972</i>		25B. NAME OF REGISTRAR <i>Sidney W. Jenkins</i>			

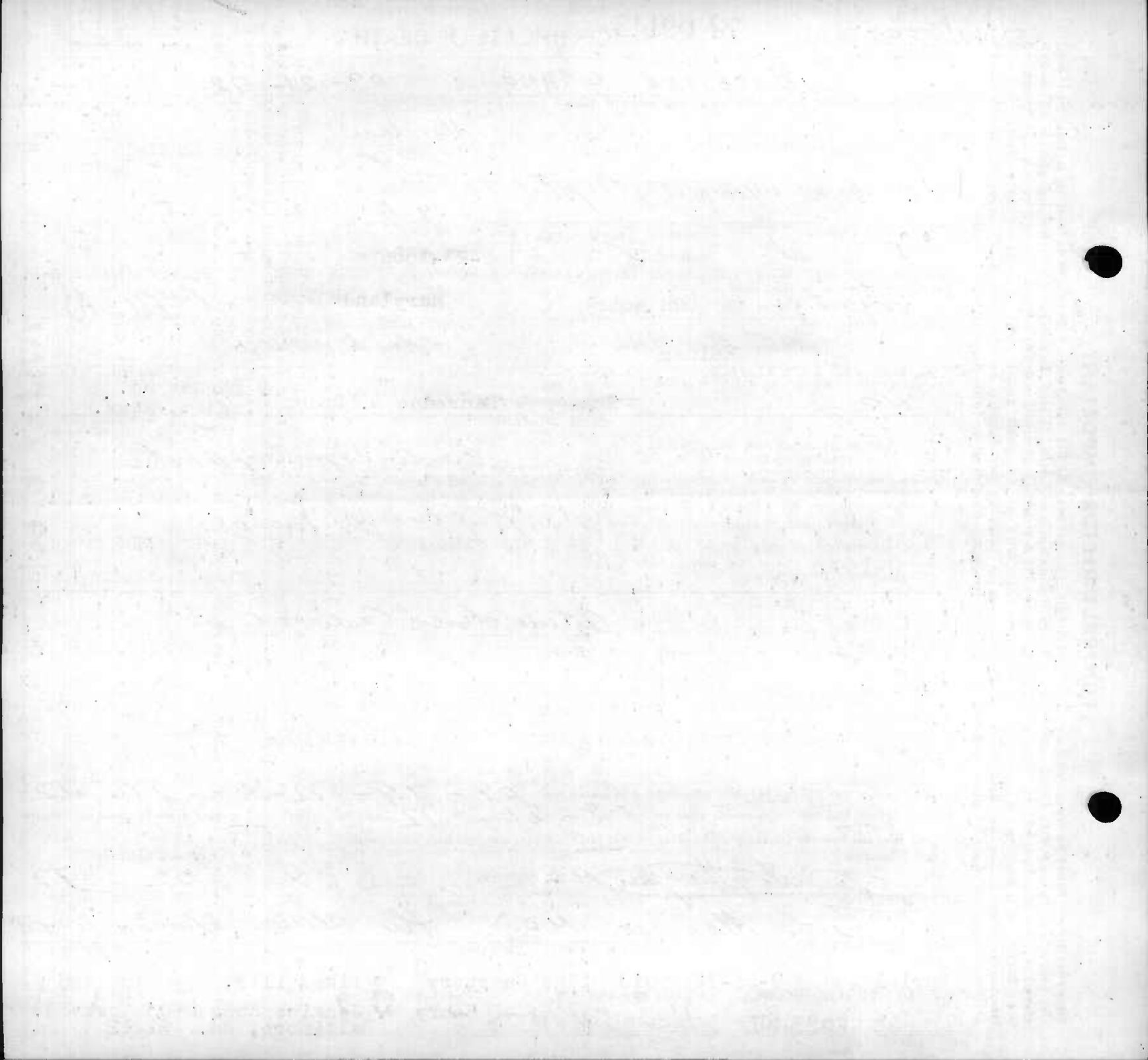


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-650		72 09143		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09143	
BIRTH NO.				STATE OF MARYLAND			
1. NAME OF DECEASED (Type or Print) <b>MADELINE CRANE</b>				2. DATE AND HOUR OF DEATH <b>09-21-72 13:33 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>The Union Memorial Hospital</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1102</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>524 N. Charles St.</b>			
5. SEX <b>F.</b>	6. RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-23-1886</b>	9. AGE (In years last birthday) <b>86</b>	10. If Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>Aug. 1886 (U.S.A.)</b>				13. FATHER'S NAME <b>Keiner</b>			
14. MOTHER'S MAIDEN NAME <b>McKowen</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO.				17. INFORMANT <b>Laurence E. Crane</b>			
18. ADDRESS <b>9 Barnes Rd. Hingham, Mass.</b>				19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardio respiratory arrest.</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Pulmonary Emboli.</b>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerosis Cardiovasc. dis.</b>				(B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Arteriosclerosis Cardiovasc. dis.</b>				21. DATE OF OPERATION			
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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 09144

BIRTH NO.

BIRTH OF MARYLAND - DEATH

1. NAME OF DECEASED (Type or Print) <b>Johnnie A. Caesar</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>9 19 72 7:42 A.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Lutheran Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>9 19 72 7:42 A.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>May 27, 1919</b>		10. AGE (In years last birthday) <b>53</b>	
11. BIRTHPLACE (State or foreign country) <b>Norfolk Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Johnnie Caesar Sr.</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Store Room Keeper</b>	
15. MOTHER'S MAIDEN NAME <b>Annie Hargrove</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW-2</b>	
17. SOCIAL SECURITY NO.		18. INFORMANT <b>Ida Winmond 720 N. Fulton Ave.</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>W P Mulloy</b> M.D. EXAMINER'S NAME (Type) <b>William P. Mulloy, M.D.</b>  CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/25/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>St. Calixtus Cem.</b>		24D. LOCATION (City, town or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 25 1972</b>		25B. NAME OF REGISTRAR <b>Andrew J. Howard</b>	
25C. FUNERAL DIRECTOR <b>Williams Funeral Home</b>		25D. ADDRESS <b>3198 N. Howard St.</b>	

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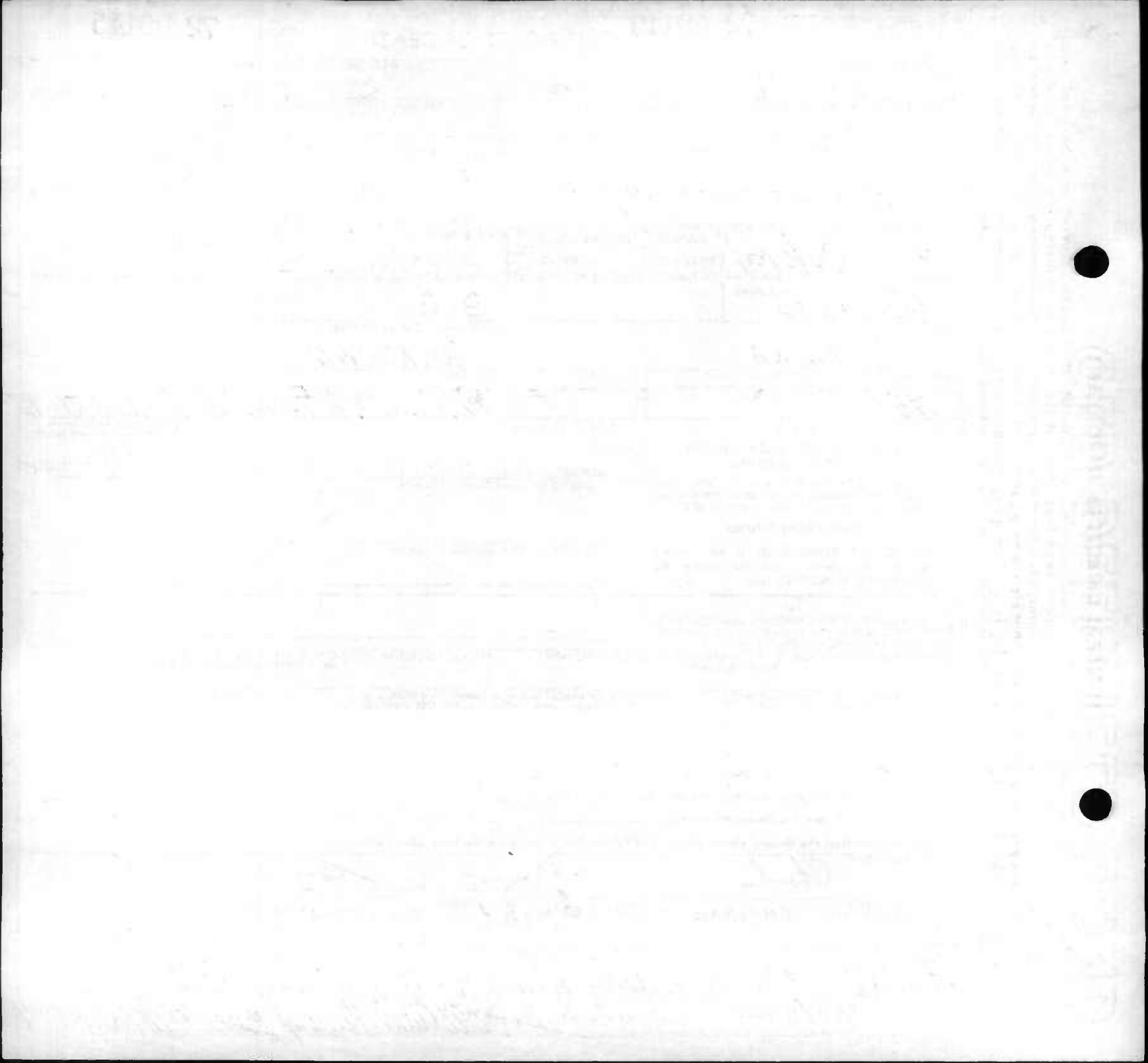
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

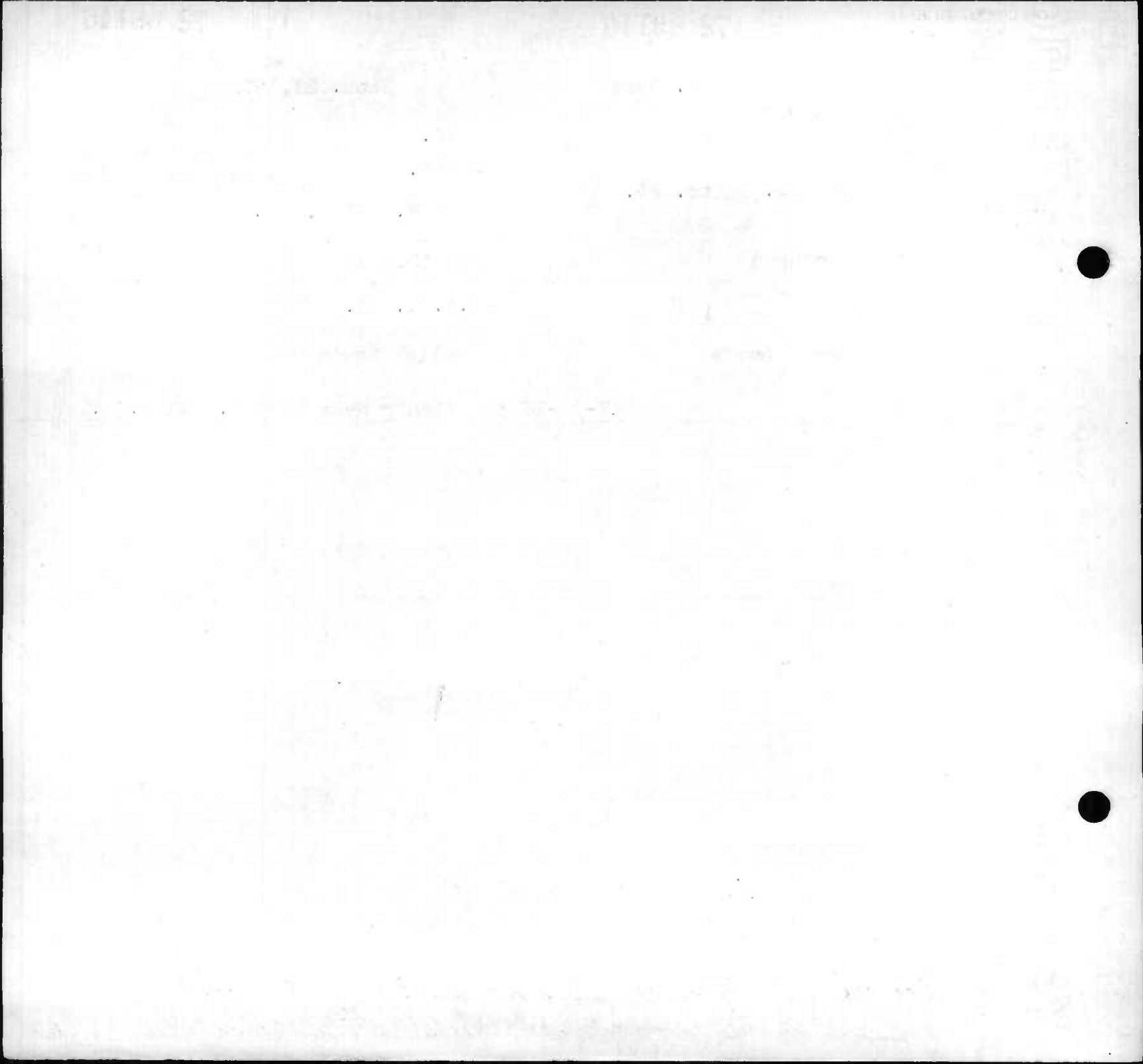
BIRTH NO. 72 09145		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09145	
1. NAME OF DECEASED (Type or Print) <b>ELISE V. White</b>			2. DATE AND HOUR OF DEATH <b>3:00 pm 9/21/72</b> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>34 Bon Secours Hospital</b>			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>808 Vine Street 1801</b>		
5. SEX <b>F</b>	6. RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/23/96</b>	9. AGE (in years last birthday) <b>75</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>S. C.</b>	
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-14-5251</b>		17. INFORMANT <b>William White 2121 Stenton Ave. Phila. Pa.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>II</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ANTecedent CAUSES</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b>			(A) IMMEDIATE CAUSE <b>METASTASIS OF CARCINOMA OF PANCREAS</b> DUE TO, OR AS A CONSEQUENCE OF: <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <b>= 1 1/2 MONTHS</b>		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8/11/1972</b> to <b>9/21/1972</b> that (I) (we) last saw the deceased alive on <b>9/21/1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Chun</b>			23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type) <b>CHAIHAN UNG-DHA KORN M.D.</b>			23D. ADDRESS <b>BON SECOURS HOSP. 2015 W. FAYETTE ST. BALTIMORE, MD 21213</b>		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>9/26/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Park</b>	
24D. LOCATION (City, town, or county) (State)		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 25 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Johnston</b>		25C. FUNERAL DIRECTOR <b>Williams Funeral Home</b>	
				ADDRESS <b>3198 Belwood Dr</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-208		72 09146		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO.		72 09146		REG. NO.	
1. NAME OF DECEASED (Type or Print)		STATE OF MARYLAND-DEMH		72 09146	
Roland R. Kess		2. DATE AND HOUR OF DEATH Sept. 21, 1972		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Md.		1903	
00 1837 W. Balto. St.		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1837 W. Balto. St.					
5. SEX Male		6. RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH May 10, 1906		9. AGE (In years last birthday) 66		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
11. BIRTHPLACE (State or foreign country) A.A.Co. Md.		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Shadrach Davis		14. MOTHER'S MAIDEN NAME Adella Davis			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-03-2833A		17. INFORMANT Elenor Kess 1837 W. Balto. St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH I. <i>Gastric Carcinoma</i> II. <i>Arteriosclerotic heart disease</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>12/24</i> 19 <i>71</i> to <i>8/30</i> 19 <i>72</i> , that (I) (we) lost saw the deceased alive on <i>Sept. 21</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Dionisio Garcia Jr.</i>		23B. DATE SIGNED 9/22/72		23C. PHYSICIAN'S NAME (Type) DIONISIO GARCIA JR.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/25/72		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem. Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 25 1972		25B. NAME OF REGISTRAR <i>Adrian W. ...</i>		25C. FUNERAL DIRECTOR <i>William ...</i>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 09147

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>Glen Grandy</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year <b>9 22 72</b>		Hour <b>M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>37 Mercy Hospital</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				3. DATE PRONOUNCED DEAD Month Day Year <b>9 22 72</b>		Hour <b>9:32 p.</b>	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1302</b>				C. CITY OR TOWN <b>Balto.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX <b>male</b>	7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <b>2330 Eutaw Place</b>			
9. DATE OF BIRTH <b>4-9-48</b>		10. AGE (In years lost birthday) <b>24</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Glenn Grandy</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME <b>Marjorie Brown</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes</b>		17. SOCIAL SECURITY NO. <b>215-52-1384</b>		18. INFORMANT ADDRESS			
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Strangulation by hanging</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) <b>yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>JAIL</b>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>Baltimore City Jail</b>		<b>1003</b>	
22D. TIME OF INJURY (APPROX.) Month Day Year Hour <b>9 22 72 9:15 p.m.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Subject hanged himself</b>			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Marvin S. Platt, M.D.</b>		DATE SIGNED <b>9/23/72</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-26-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 25 1972</b>		25B. NAME OF REGISTRAR <b>Dr. J. H. Brown</b>		25C. FUNERAL DIRECTOR <b>J. C. Smith</b>		ADDRESS <b>2200 Edmondson Ave.</b>	



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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>17245</b>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 09148</b>
1. NAME OF DECEASED (Type or Print) <b>McLAIN, ALLAN CHARLES</b>		2. DATE AND HOUR OF DEATH <b>9-20-72 11:00 AM</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>23 Veterans Administration Hospital 3900 Loch Raven Blvd., Baltimore, Md. 21218</b>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1701</b>		
5. SEX <b>MALE</b>		6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/25/10</b>
9. AGE (In years last birthday) <b>62</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)
10A. <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>CHARLES McLAIN</b>		14. MOTHER'S MAIDEN NAME <b>SARA Rosier</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES 8/7/44 to 10/22/45</b>
16. SOCIAL SECURITY NO. <b>216 10 89 08</b>		17. INFORMANT ADDRESS <b>Medical Records VA Hospital Baltimore, Md. 21218</b>		
18. <b>3-32-71</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Resp. Arrest</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Aspiration pneumonia</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Amyotrophic Lateral Schrosis</b>				
19A. DATE OF OPERATION <b>3 9-12-72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Gastrostomy &amp; Traceostomy</b>		20A. AUTOPSY? (Yes or No) <b>yes</b>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>September 7 19 72</b> to <b>September 20 19 72</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>September 20 19 72</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (not) view the body after death.				
23A. SIGNATURE <b>[Signature]</b>		23B. DATE SIGNED <b>9-21-72</b>		23C. PHYSICIAN'S NAME (Type) <b>James Witten, M.D.</b>
23D. ADDRESS <b>VA Hospital, Balto., Md. 21218</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		
24B. DATE <b>9/22/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Security Process INC.</b>		24D. LOCATION (City, town, or county) (State) <b>Catonsville Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 25 1972</b>		25B. NAME OF REGISTRAR <b>Sidney H. Hoston</b>		25C. FUNERAL DIRECTOR <b>Henry Sanders &amp; Sons Inc. 1649 E. North</b>



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09149 4
CERTIFICATE OF DEATH				REG. NO. 72 09149 4
BIRTH NO. <u>92-14334</u>		CELINE DAWN GLOCK		STATE OF MARYLAND-DEMD
1. NAME OF DECEASED (Type or Print)		BABY GIRL (B) GLOCK		2. DATE AND HOUR OF DEATH 9-23-72 6:53 P.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN BALTIMORE		
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 1103 ARGONNE DR.				
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-22-72	9. AGE (in years last birthday) 21
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME CARL GLOCK		14. MOTHER'S MAIDEN NAME RUTH APGAR		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MR CARL S. GLOCK 1103 ARGONNE DRIVE
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardio Respiratory arrest Hyaline Membrane Disease Systemic Acidosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours 21 hours 4 hours
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>Sept. 22</u> 19 <u>72</u> to <u>Sept. 23</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>Sept 23</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Janet E. Graeber MD.</u>		23B. DATE SIGNED 9/23/72		
23C. PHYSICIAN'S NAME (Type) JANET E. GRAEBER, MD		23D. ADDRESS THE JOHNS HOPKINS HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/25/72		24C. NAME OF CEMETERY or CREMATORY First Evangelical Church Cem. Baltimore Maryland
24D. LOCATION (City, town, or county) (State) BALTO. MD.				
25A. DATE REC'D BY HEALTH DEPT. SEP 25 1972		25B. NAME OF REGISTRAR <u>Sidney Johnston</u>		25C. FUNERAL DIRECTOR HENRY SANDER & SONS INC.

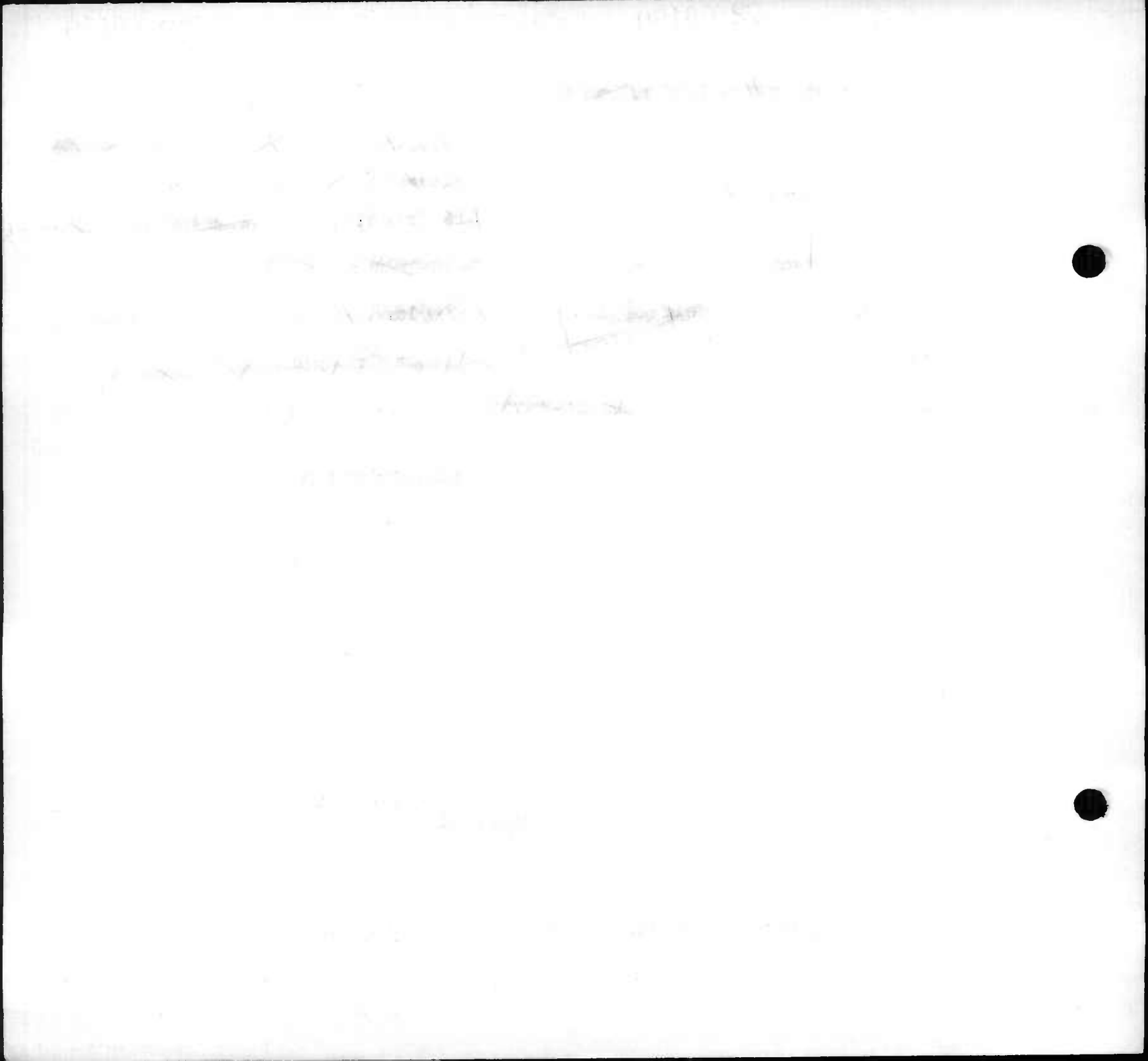
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-520		72 09150		BALTIMORE CITY HEALTH DEPARTMENT		72 09150	
BIRTH NO.				CERTIFICATE OF DEATH		REG. NO. STATE OF MARYLAND-DEATH	
1. NAME OF DECEASED (Type or Print) Margaret Ann Banks				2. DATE AND HOUR OF DEATH 9-19-72 6:34 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Bon Secours Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 616 Grantley Street			
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-15-1927	9. AGE (in years last birthday) 44	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) caterer		10B. KIND OF BUSINESS OR INDUSTRY self-employed		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wardell Davis				14. MOTHER'S MAIDEN NAME Amanda Frazier			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-26-4872		17. INFORMANT ADDRESS Mrs. Phyllis Massey 616 Grantley St.			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: BRONCHOPNEUMONITIS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 WKS.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White <input type="checkbox"/> At Work Not White <input type="checkbox"/> At Work		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 9/18/72 to 9/19/72 that (I) (we) last saw the deceased alive on 9/19/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Clayton M.D.				23B. DATE SIGNED 9/19/72			
23C. PHYSICIAN'S NAME (Type) CHAIHAN UNGOHAKORN M.D.				23D. ADDRESS BON SECOURS HOSP.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-23-72		24C. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore Co., Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 25 1972		25B. NAME OF REGISTRAR Sidney Whitson		25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME 3035 W. NORTH AVE.			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 09151</u>	
<p><b>P-320</b> <b>72 09151</b></p> <p>BIRTH NO.</p> <p>1. NAME OF DECEASED (Type or Print) <u>Ella Mae Pettus</u></p>		<p>2. DATE AND HOUR OF DEATH <u>9-19-72</u> <u>11:30 A.M.</u></p>			
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Singai Hospital of Balto.</u></p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1304</u></p> <p>C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <u>3508 Holmes Avenue</u></p>			
<p>5. SEX <u>Female</u> 6. RACE <u>Negro</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>6-23-1926</u> 9. AGE (In years, last birthday) <u>46</u></p> <p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clerk</u> 10B. KIND OF BUSINESS OR INDUSTRY <u>Social Security Administration</u></p>			
<p>11. BIRTHPLACE (State or foreign country) <u>Maryland</u></p>		<p>12. CITIZEN OF WHAT COUNTRY? <u>USA</u></p>		<p>13. FATHER'S NAME <u>William E. Braxton</u></p>	
<p>14. MOTHER'S MAIDEN NAME <u>Ella Cox</u></p>		<p>15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>220-22-9854</u></p>			
<p>17. INFORMANT <u>Mrs. Sylvia Gaither</u> ADDRESS <u>5716 Winner Ave.</u></p>		<p>18. CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Metastatic Carcinoma.</u></p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>W. Ovary</u></p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____</p> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Months</u> <u>Years</u></p>			
II					
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>					
<p>19A. DATE OF OPERATION <u>9-23-72</u></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No) <u>No</u></p>	
<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>		<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>			
<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>			
<p>21D. TIME OF INJURY (APPROX.)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <u>9-23-72</u> to <u>9-19-72</u> that (I) (we) last saw the deceased alive on <u>9-19-72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE <u>John Nutter</u></p>				<p>23B. DATE SIGNED <u>9-19-72</u></p>	
<p>23C. PHYSICIAN'S NAME (Type) <u>John Nutter MD.</u></p>				<p>23D. ADDRESS <u>Singai Hosp Baltimore, Md.</u></p>	
<p>24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u></p>		<p>24B. DATE <u>9-23-72</u></p>		<p>24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Memorial Park</u></p>	
<p>24D. LOCATION (City, town, or county) <u>Baltimore Co., Maryland</u></p>		<p>25A. DATE REC'D BY HEALTH DEPT. <u>SEP 25 1972</u> 25B. NAME OF REGISTRAR <u>Aidyn Houston</u></p>			
<p>25C. FUNERAL DIRECTOR <u>NUTTER FUNERAL HOME</u> ADDRESS <u>3035 W. NORTH AVE.</u></p>				<p>25D. DATE OF DEATH <u>9-19-72</u></p>	

[REDACTED]

[REDACTED]

1. [REDACTED]  
2. [REDACTED]  
3. [REDACTED]  
4. [REDACTED]  
5. [REDACTED]

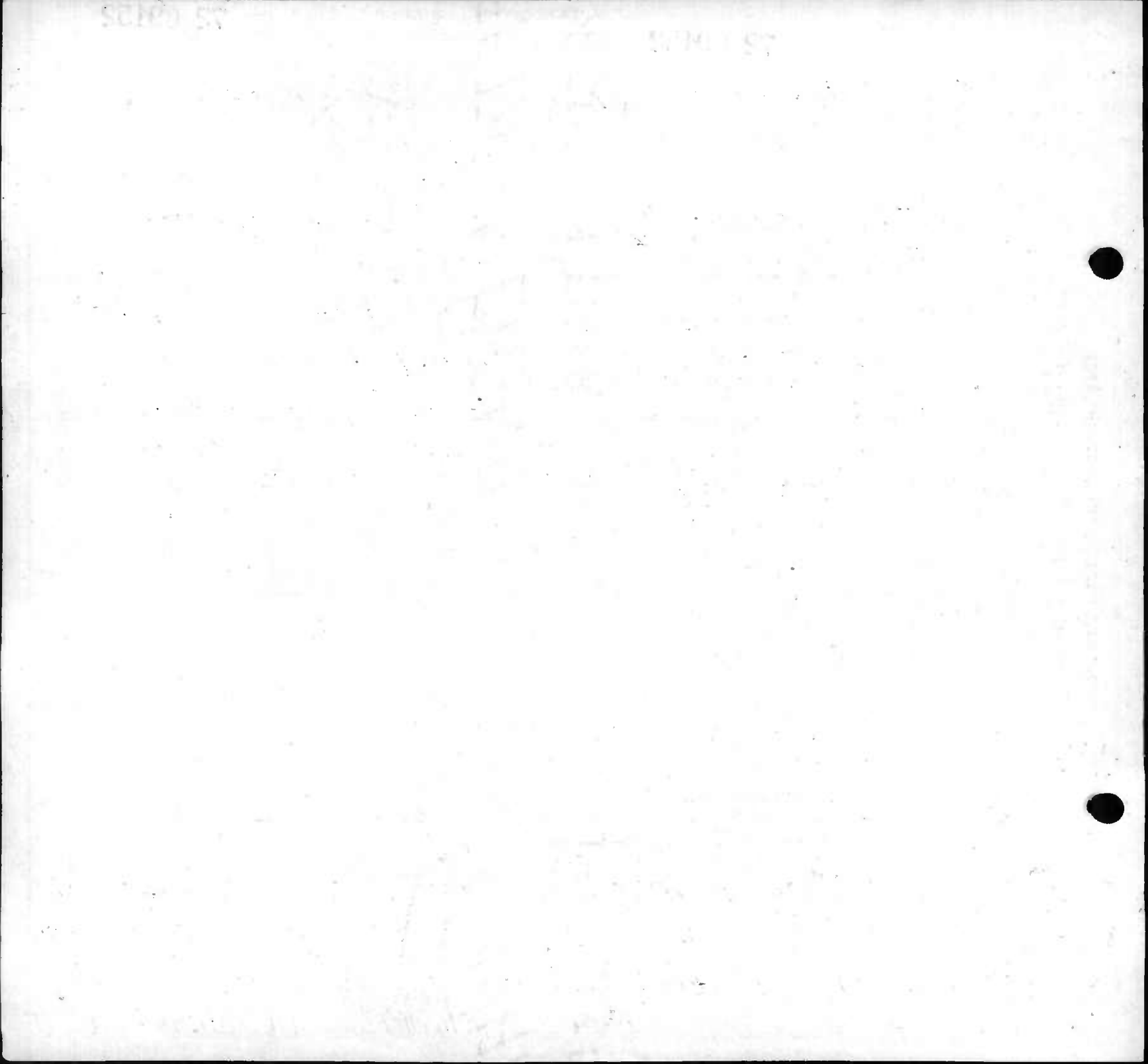




# FUNERAL DIRECTOR: IMPORTANT

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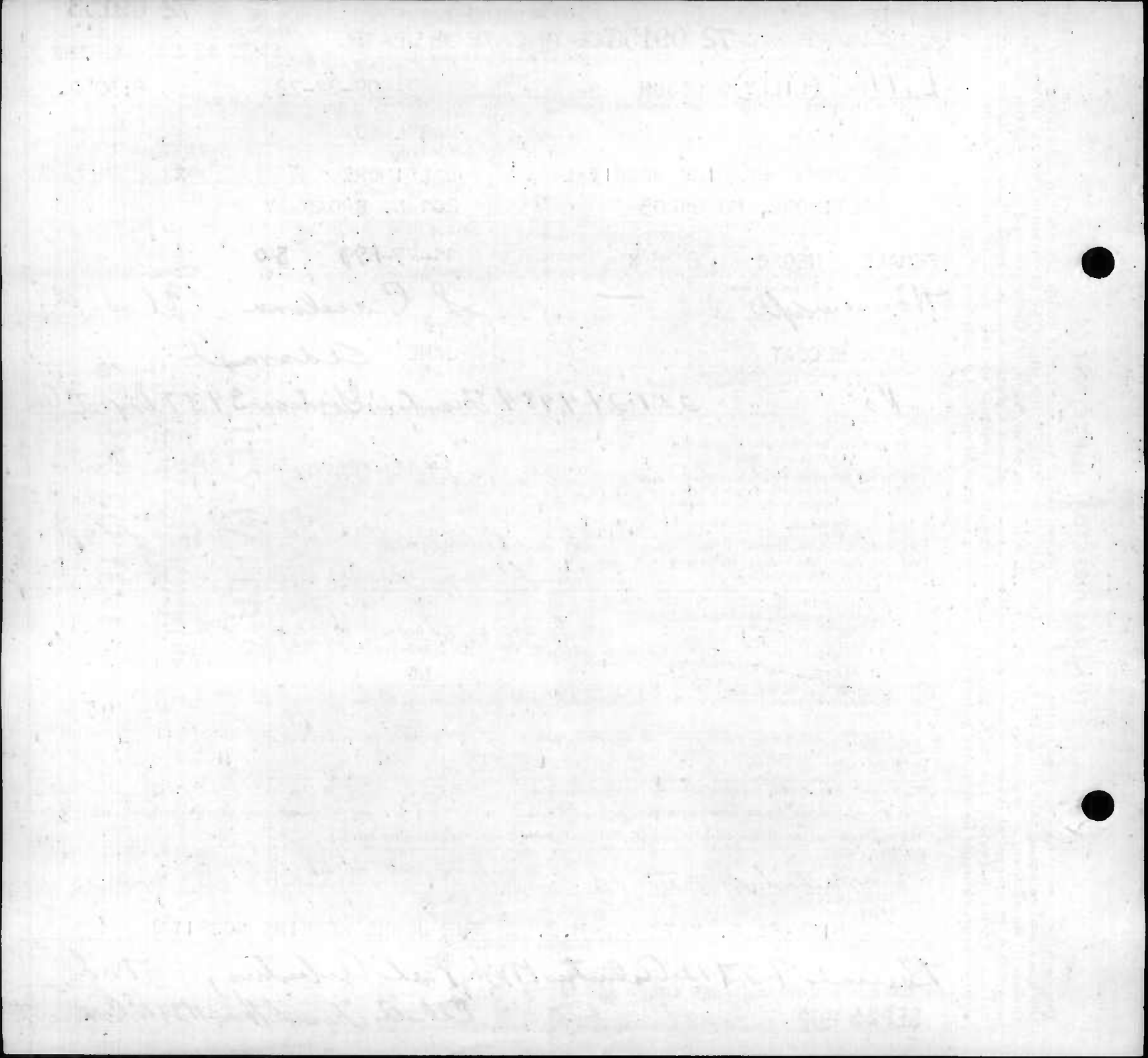
BALTIMORE CITY HEALTH DEPARTMENT				72 09152		REG. NO. 72 09152	
G-630				72 09152			
BIRTH NO.				72 09152			
1. NAME OF DECEASED (Type or Print) <u>ELMA I. MA Grady</u>				2. DATE AND HOUR OF DEATH <u>9-19-72</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>908</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>2033 Kennedy Ave.</u>				C. CITY OR TOWN <u>BALTO.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F.</u> 6. RACE <u>C.</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>5-25-06</u>		9. AGE (In years last birthday) <u>66</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>N. Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Herbert Strong</u>			
14. MOTHER'S MAIDEN NAME <u>Lucy Dixon</u>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Jasper Grady - 4118 Fairview Ave.</u>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <u>9-23-72</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <u>No</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>August</u> 19 <u>64</u> to <u>9/19</u> 19 <u>72</u> , that (I) ( <del>was</del> ) last saw the deceased alive on <u>Sept. 5</u> 19 <u>1972</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>was</del> ) ( <del>did</del> ) view the body after death.							
23A. SIGNATURE <u>Jesse T. Holmes MD</u>				23B. DATE SIGNED <u>9/21/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Jesse T. Holmes</u>	
23D. ADDRESS <u>508 E North Ave. Balto, Md.</u>				24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>9-23-72</u>				24C. NAME OF CEMETERY OR CREMATORY <u>Arbutus Mem. Park</u>		24D. LOCATION (City, town, or county) (State) <u>Arbutus, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 25 1972</u>				25B. NAME OF REGISTRAR <u>Adrienne H. Hinton</u>		25C. FUNERAL DIRECTOR <u>Elliott Funeral Home 1129 N. Caroline ST</u>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

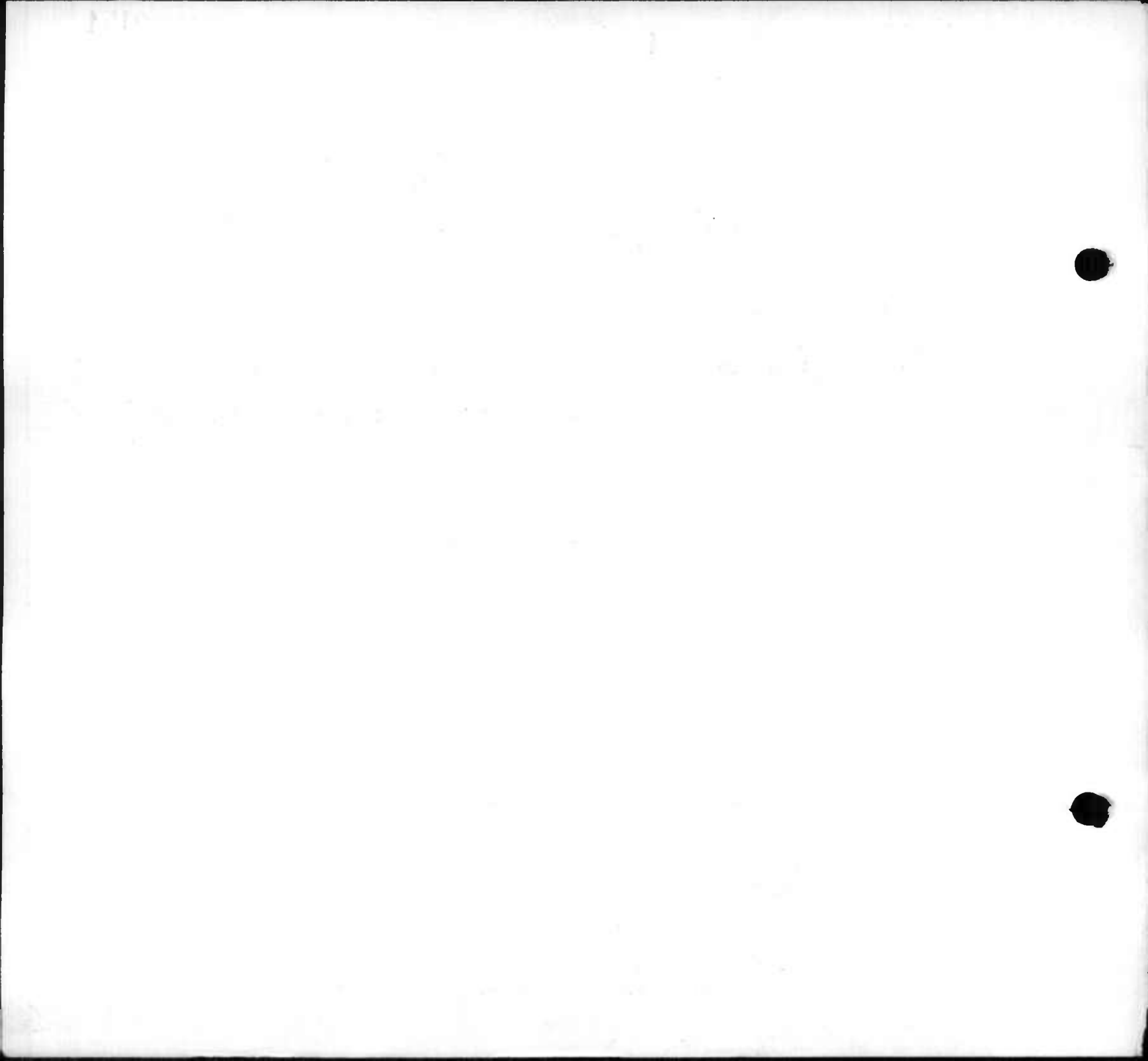
BALTIMORE CITY HEALTH DEPARTMENT				72 09153
72 09153 CERTIFICATE OF DEATH				REG. NO. _____
STATE OF MARYLAND-DEPT				604
1. NAME OF DECEASED (Type or Print) <b>Lillie (LILLY) GOODSON</b>		2. DATE AND HOUR OF DEATH <b>09-22-72 6:30 P. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY _____ C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>201 N. BROADWAY</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-27-1897</b>	9. AGE (In years lost birthday) <b>80</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>S. Carolina</b>
13. FATHER'S NAME <b>DARK BECOAT</b>		14. MOTHER'S MAIDEN NAME <b>JANE Adame</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>351-244984</b>		17. INFORMANT <b>Franklin Goodson</b>
18. <b>447X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cardiorespiratory arrest</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Systemic vasculitis</b> <b>Etiology unknown</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>3 days</b>		
<b>II</b>				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Pulmonary edema, chronic + acute renal failure, pulmonary embolus</b>				
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>NO</b>		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (H) (his hospital) attended the deceased from <b>8/26</b> 19 <b>72</b> to <b>9/22</b> 19 <b>72</b> , that (H) (we) last saw the deceased alive on <b>9/22</b> 19 <b>72</b> and that in (H) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Michael S. Katz, MD</b>		23B. DATE SIGNED <b>9/22/72</b>		23C. PHYSICIAN'S NAME (Type) <b>MICHAEL S. KATZ M.D.</b>
23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		
24B. DATE <b>9-27-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Arbuthnot Mem. Park</b>		24D. LOCATION (City, town, or county) (State) <b>Arbuthnot, Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 25 1972</b>		25B. NAME OF REGISTRAR <b>Sidney [Signature]</b>		25C. FUNERAL DIRECTOR <b>Ellie [Signature]</b>
25D. ADDRESS <b>1129 N. Caroline St.</b>				



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-350		72 09154		BALTIMORE CITY HEALTH DEPARTMENT		72 09154	
BIRTH NO.		72 09154		REG. NO.		72 09154	
1. NAME OF DECEASED (Type or Print) <u>STEIN JOLENA</u>				2. DATE AND HOUR OF DEATH <u>9-14-72</u> <u>2-30 PM</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>1603</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>LUTHERAN HOSPITAL</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>BAITIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F.</u>		6. RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-30-37</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <u>34</u>		11. BIRTHPLACE (State or foreign country) <u>OHIO</u>	
13. FATHER'S NAME <u>Joseph Eches</u>		14. MOTHER'S MAIDEN NAME <u>Marie Elswick Tronton, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Alberta Marie Nobel</u>		ADDRESS <u>13478 MD. 21216 Sidney Ave.</u>		18. CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <u>Hepatic Comma</u> DUE TO, OR AS A CONSEQUENCE OF:			
				(B) <u>Hepato cellular jaundice</u> DUE TO, OR AS A CONSEQUENCE OF:			
				(C) _____			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <u>9-13-72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		21G. WHERE DID INJURY OCCUR?		21H. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9-13-1972</u> to <u>9-14-1972</u> that (I) (we) last saw the deceased alive on <u>9-14-1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Javed H. Siddiqi</u> M.D.				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>JAVED H. SIDDIQI, M.D.</u>	
23D. ADDRESS <u>Lutheran Hospital</u>				23E. ADDRESS		23F. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-22-72</u>		24C. NAME of CEMETERY or CREMATORY <u>Lawrence G. Lawrence</u>		24D. LOCATION (City, town, or county) (State) <u>Lawrence G. Lawrence Co. Ohio</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 25 1972</u>		25B. NAME OF REGISTRAR <u>J. J. Schaub, Jr.</u>		25C. FUNERAL DIRECTOR <u>J. J. Schaub, Jr.</u>		25D. ADDRESS <u>21223</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09155	
CERTIFICATE OF DEATH				STATE OF MARYLAND-DEHE	
BIRTH NO. M-242		72 09155		1. NAME OF DECEASED (Type or Print) <u>Michaelis Charles</u>	
2. DATE AND HOUR OF DEATH <u>9/23/72</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Harbor View Nursing Home</u>			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Baltimore, Maryland</u> B. COUNTY <u>1903</u>		5. SEX <u>M</u> 6. RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8. DATE OF BIRTH <u>8/13/93</u> 9. AGE (In years last birthday) <u>79</u>			
E. STREET AND NUMBER <u>1213 Light Street</u>		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> 10B. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>			
11. BIRTHPLACE (State or foreign country) <u>Baltimore, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Charles</u>		14. MOTHER'S MAIDEN NAME <u>1832 McHenry St. Baltimore, MD 21223</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>205-12-4994</u>		17. INFORMANT <u>Mrs. D.L. Kirby</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Terminal Broncho Pneumonia</u>		CAUSE OF DEATH <u>4 days</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>CVA - (old)</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>A.S.C.V. Disease</u>		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>?</u>	
(C) <u>6 mo</u>		19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>No</u>		20A. AUTOPSY (Yes or No) <u>No</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8/1</u> 19 <u>71</u> to <u>9/22</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>9/22</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Joseph S. Beum</u>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>9/23/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>JOSEPH S. BEUM</u>		23D. ADDRESS <u>1115-H Calvert St</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/26/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Westminster</u>	
24D. LOCATION (City, town, or county) <u>Baltimore, Md.</u>		(State) <u>Baltimore, Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 25 1972</u>		25B. NAME OF REGISTRAR <u>John J. Schuch</u>		25C. FUNERAL DIRECTOR <u>2101 Frederick Ave. Balt. Md.</u>	



11/13/71

1832 McHenry St. 21230



72 09156

STATE OF MARYLAND-DEPT.  
BALTIMORE CITY HEALTH DEPARTMENT

72 09156

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>WILLIE SMITH JR.</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>PROVIDENT HOSPITAL (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>September 21, 1972 2:33 P.</b> M.	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>10-5-35</b>		10. AGE (In years last birthday) <b>36</b> If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Willie Smith Sr.</b>		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>802</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME <b>Lucille Lincoln</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. <b>218-26-6942</b>		18. INFORMANT ADDRESS <b>Pearline Yancey 1920 Patterson Park</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Gunshot wound of head</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Apartment</b>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>1648 Gwyns Falls Pkwy</b>		22D. TIME (Month) (Day) (Year) (Hour) (Approx.) <b>9-21-72 2:20 P.</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Shot while attempting to burglarize apt.</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) DATE SIGNED <b>9/22/72</b> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-27-72</b>	
24C. NAME of CEMETERY or CREMATORY <b>Mt Calvary Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Anne Arundel Cty., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 25 1972</b>		25B. NAME OF REGISTRAR <b>Andrew H. ...</b>	
25C. FUNERAL DIRECTOR <b>Wm d March</b>		ADDRESS <b>928 E North Ave.</b>	

UNITED STATES DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C.

OFFICE OF THE ASSISTANT SECRETARY FOR TECHNICAL ASSISTANCE

TECHNICAL ASSISTANCE TO THE DEVELOPING COUNTRIES

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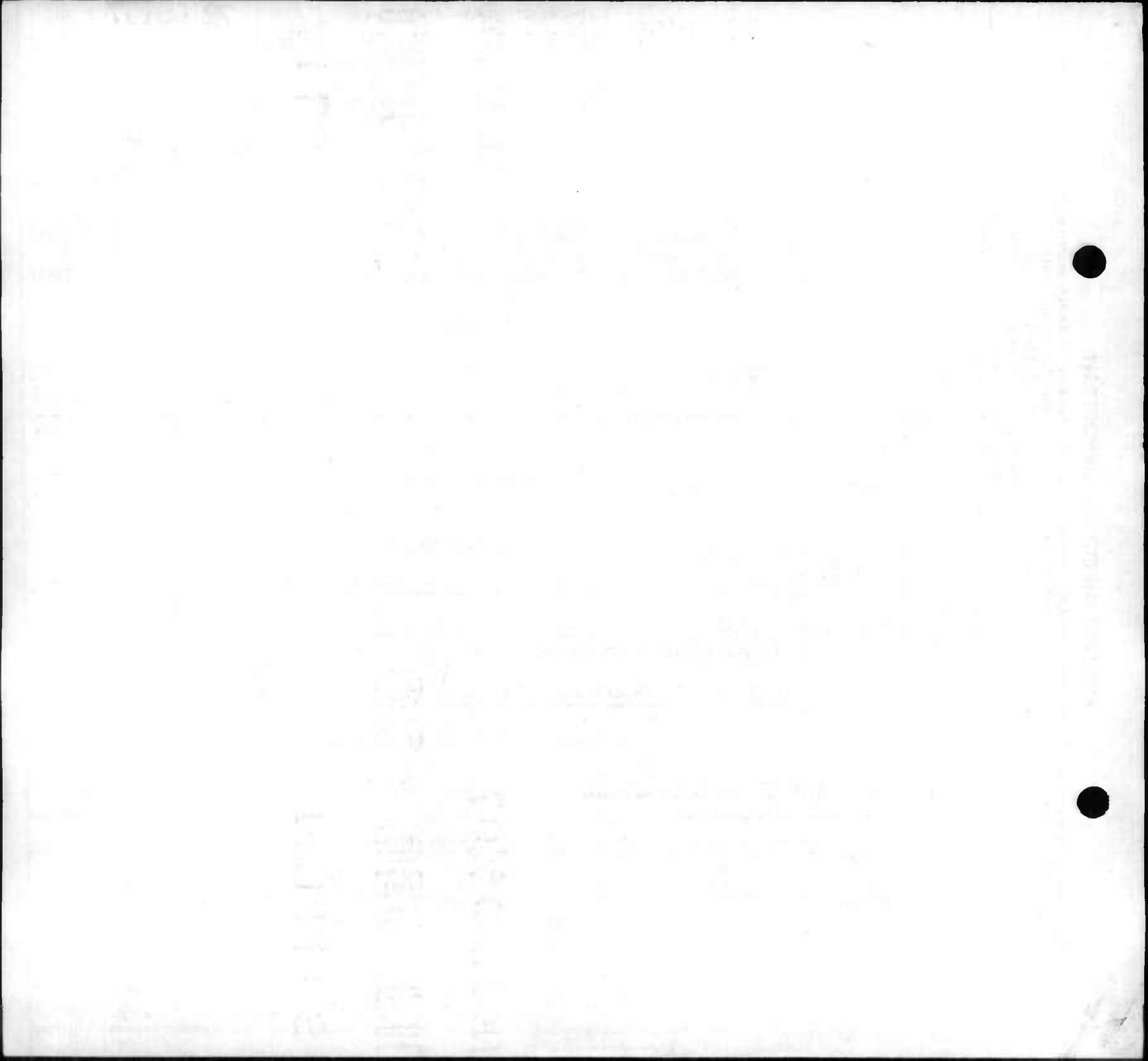
TECHNICAL ASSISTANCE TO THE DEVELOPING COUNTRIES

TECHNICAL ASSISTANCE TO THE DEVELOPING COUNTRIES

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 72 09157 72 09157 BIRTH NO. 4-200 CERTIFICATE OF DEATH				REG. NO. 72 09157 STATE OF MARYLAND - DEATH	
1. NAME OF DECEASED (Type or Print) <b>JOHN HOOKS</b>			2. DATE AND HOUR OF DEATH <b>9/20/72 3:30 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2000 LIBERTY HORTS. AVE. BALTIMORE, MD 21215</b> <b>Quoniam Hospital Inc.</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1547</b>		
			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>3032 WINDSOR AVE. 21216</b>		
5. SEX <b>M</b>	6. RACE <b>W B</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-15-07</b>		9. AGE (In years last birthday) <b>65 yrs.</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>911-19-3754</b>		17. INFORMANT ADDRESS <b>MRS. HELENA COX 3032 WINDSOR AVE.</b>
18. <b>486X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Bilateral Pneumonia</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Chronic Brain Syndrome</b> <b>Prob. General Paralysis of the Insane</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>August 25</b> 19 <b>72</b> to <b>Sept. 20</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>Sept. 20</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Virginia Fausto-Mercado</b> DEGREE				23B. DATE SIGNED <b>9/20/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>VIRGINIA FAUSTO-MERCADO</b> DEGREE				23D. ADDRESS <b>Quoniam Hospital Inc.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/22/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>174. Cokary Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>Anne Arundel Cty., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 25 1972</b>		25B. NAME OF REGISTRAR <b>Admiral [Signature]</b>		25C. FUNERAL DIRECTOR <b>Wm. C. March 928 E. NORTH AVE</b>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 09158

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Darnell Hutchins</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>9 22 72</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Union Memorial Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>9 22 72 11:45 P.M.</b>	
6. SEX <b>male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>7-19-53</b>		10. AGE (In years last birthday) <b>19</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Robert Gunter</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	
15. MOTHER'S MAIDEN NAME <b>Bernice Ray</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS <b>Bernice E. Hutchins 2800 Harford Rd.</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Shotgun wound of abdomen</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2/28/72</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>STREET</b>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>2700 block of The Alameda</b>		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <b>9 22 72 11:03 P.M.</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Subject was shot.</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Marvin S. Platt</b> M.D. EXAMINER'S NAME (Type) <b>Marvin S. Platt, M.D.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-28-72</b>	
24C. NAME of CEMETERY or CREMATORY <b>Balto. Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 25 1972</b>		25B. NAME OF REGISTRAR <b>L. M. C. March</b>	
25C. FUNERAL DIRECTOR ADDRESS <b>928 E North Ave.</b>			

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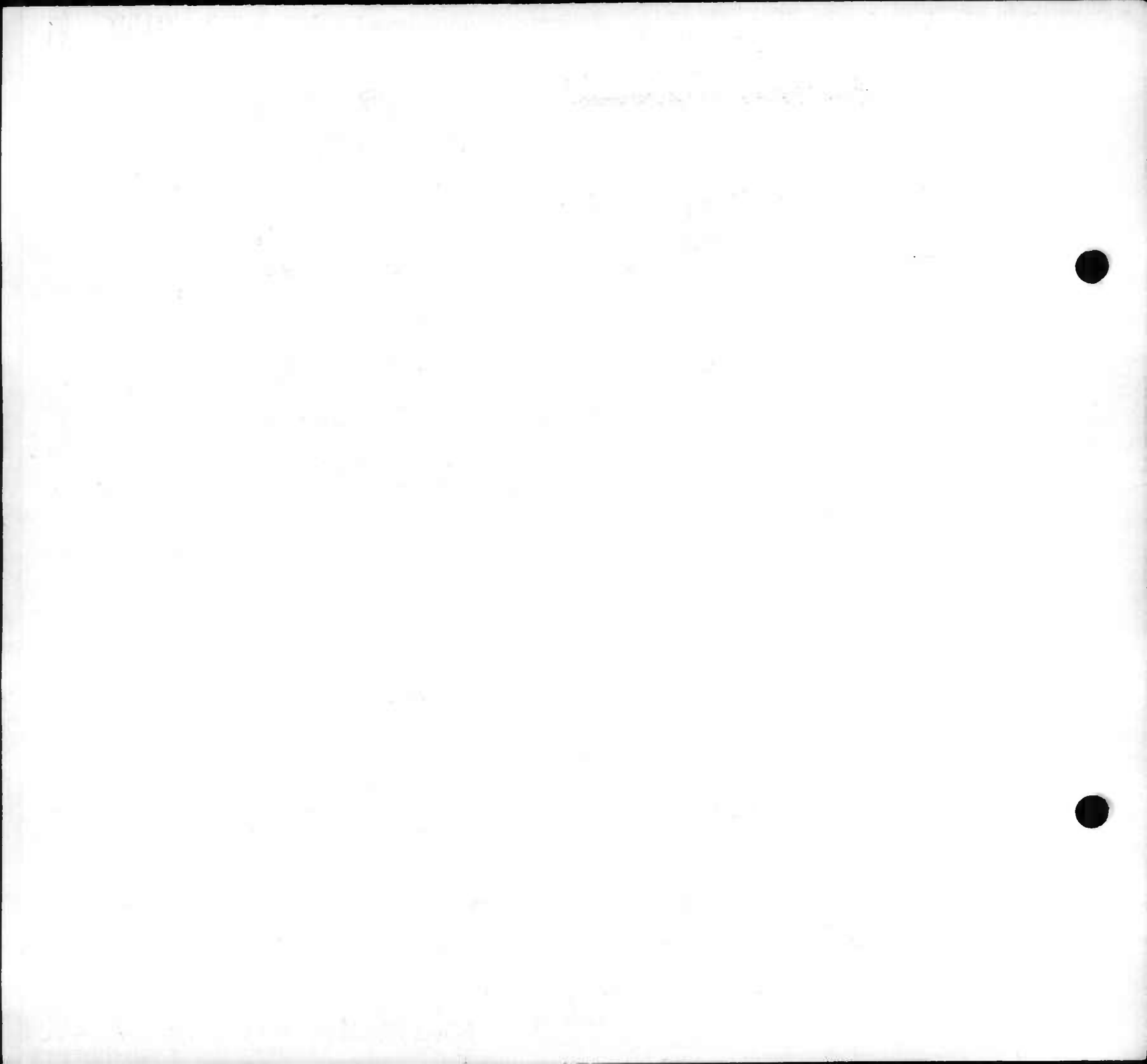
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# FUNERAL DIRECTOR: IMPORTANT

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7-626		72 09159		BALTIMORE CITY HEALTH DEPARTMENT		722 09159	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.		STATE OF MARYLAND - DIED	
1. NAME OF DECEASED (Type or Print) <b>OZELLA FRAZIER</b>		2. DATE AND HOUR OF DEATH <b>9-22-72</b>		7:10 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE <b>MD.</b>		B. COUNTY <b>BALTO.</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>UMV. HOSPITAL, BALTO.</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTO.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>639 MOSHER ST.</b>		5. SEX <b>F</b>		6. RACE <b>N</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>2-4-86</b>		9. AGE (In years last birthday) <b>86</b>		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>George PALMER</b>		14. MOTHER'S MAIDEN NAME <b>MARY</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-32-0389</b>	
17. INFORMANT <b>Robert Frazier</b>		ADDRESS <b>639 MOSHER ST</b>		18. CAUSE OF DEATH <b>I</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Renal Failure</b>		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C) DUE TO, OR AS A CONSEQUENCE OF:		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION <b>9-22-72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9-20</b> 19 <b>72</b> to <b>9-22</b> 19 <b>72</b> that (I) (we) lost the deceased alive on <b>9-22</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <b>[Signature]</b>		23B. DATE SIGNED <b>9/22/72</b>		23C. PHYSICIAN'S NAME (Type) <b>A. C. PREVIZATOS</b>	
23D. ADDRESS <b>1205 SA. PARK SA Balto 21202</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-26-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Anne Arundel Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 25 1972</b>		25B. NAME OF REGISTRAR <b>[Signature]</b>		25C. FUNERAL DIRECTOR <b>WMC MARCH</b>	
ADDRESS <b>928 E. North Ave</b>							

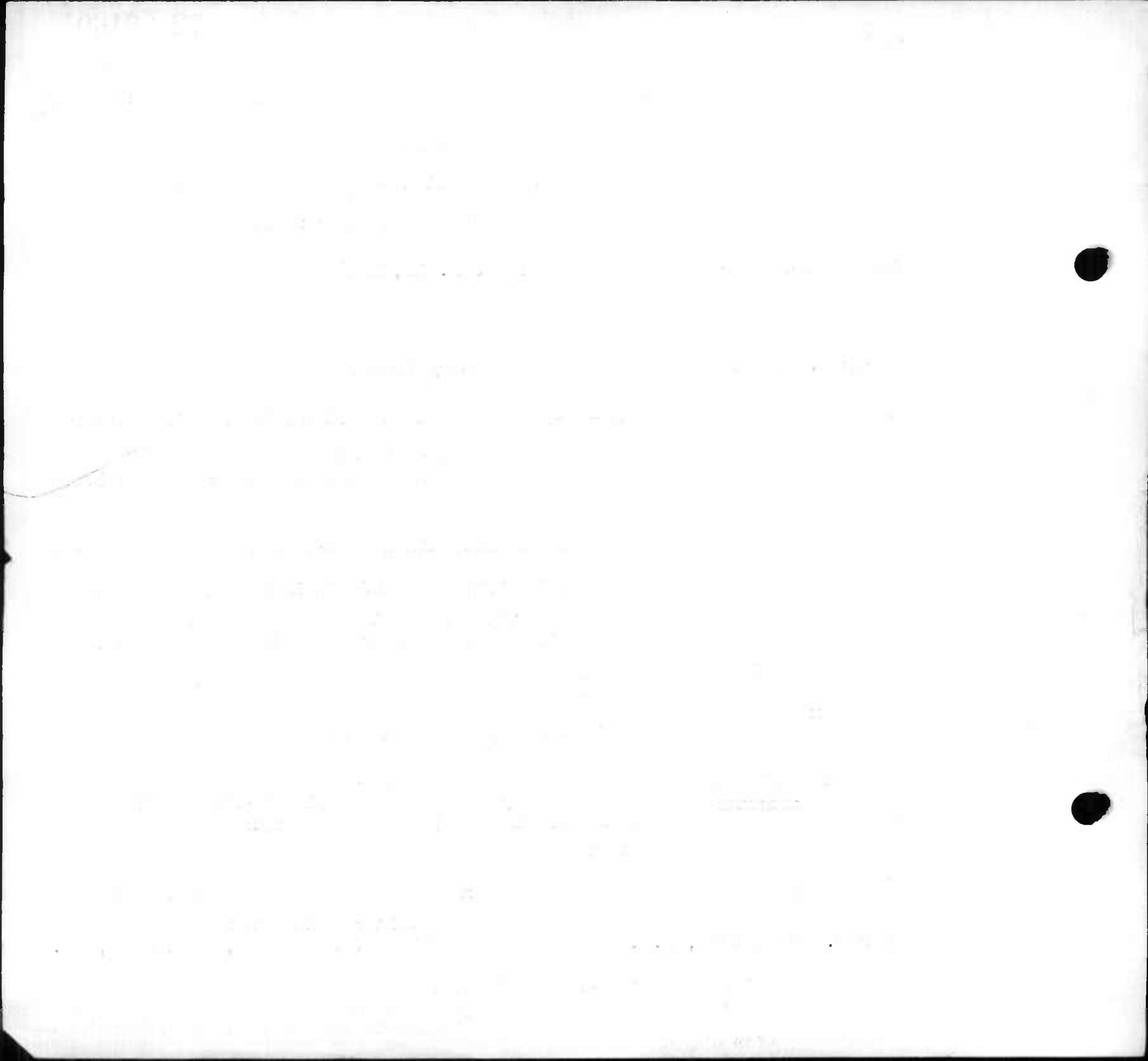




# FUNERAL DIRECTOR: IMPORTANT

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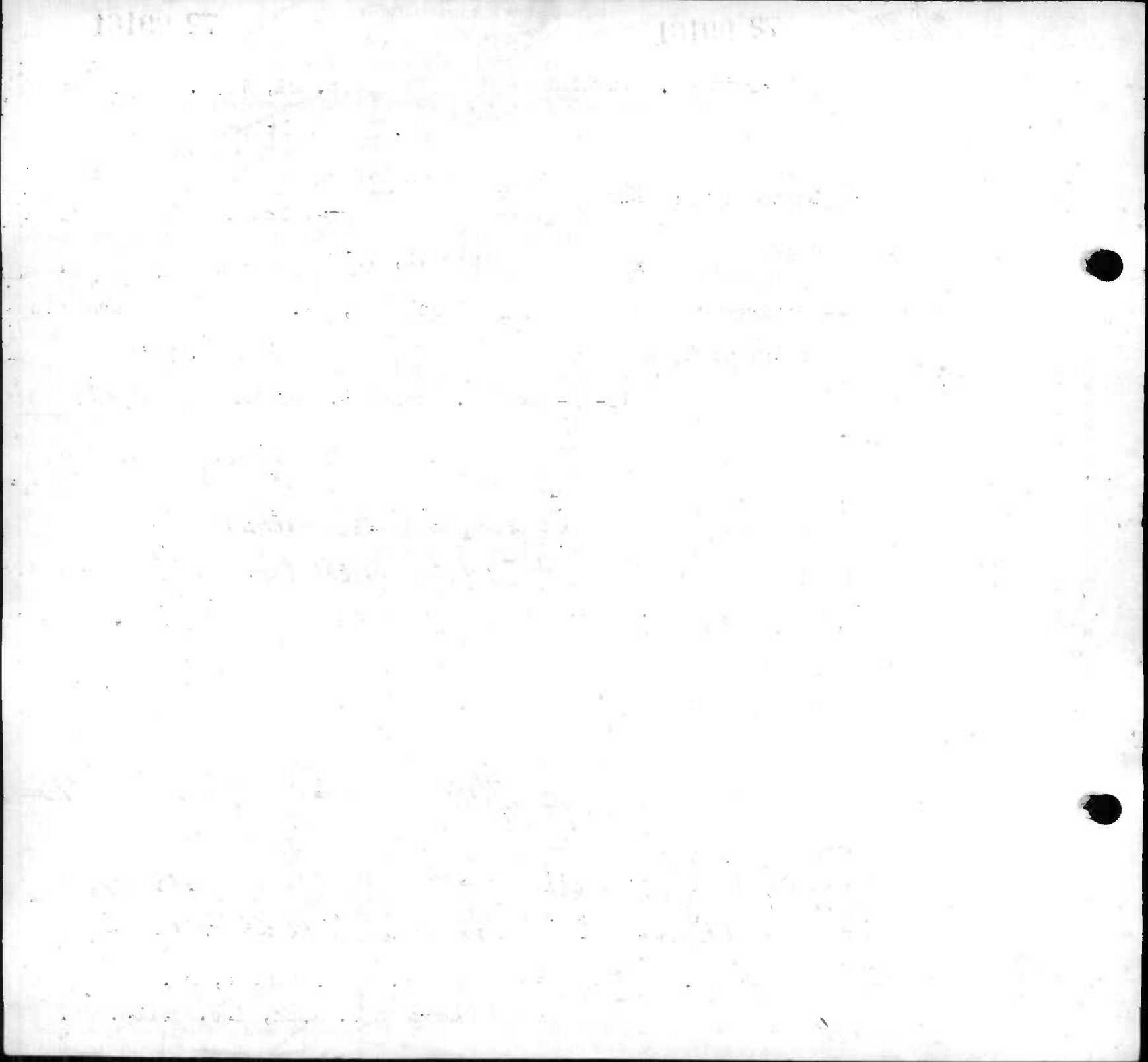
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. STATE OF MARYLAND-DHMH
7-656		72 (9160)		72 09160
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Harry Preston Turner</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <b>September 21, 1972 12:00 Noon M.</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Maryland General Hospital</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2201</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <b>129 West Lee Street</b>				
5. SEX <b>Male</b>	6. RACE <b>Black</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 11, 1928</b>	9. AGE (in years last birthday) <b>44</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
13. FATHER'S NAME <b>Harry P. Turner</b>		14. MOTHER'S MAIDEN NAME <b>Mary Brooks</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>212-20-7293</b>		17. INFORMANT <b>Chart at Bolton Hill Nursing Center</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., head failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>E 947X1</b>		CAUSE OF DEATH <b>Dehydration and Electrolyte Imbalance</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Lower Intestinal Obstruction</b>		<b>48 hours</b>
		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Adhesions from Abdominal Surgery</b>		<b>Years</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<b>Spastic Paraplegia and Neurogenic Bladder from Trauma to Spine</b>		<b>20 Years</b>
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Unknown</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Unknown</b>
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>About 20 yrs ago</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Unknown</b>
22. I certify that (I) (the hospital) attended the deceased from <b>May 20</b> 19 <b>71</b> to <b>September 21</b> 19 <b>72</b> and that (I) (we) last saw the deceased alive on <b>September 21</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Peter H. Rheinstein, M.D.</b>		23B. DATE SIGNED <b>Sept/23/1972</b>		
23C. PHYSICIAN'S NAME (Type) <b>Peter H. Rheinstein, M.D.</b>		23D. ADDRESS <b>Bolton Hill Nursing Center 1400 John Street, Baltimore, Md.</b>		
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>9/26/72</b>	24C. NAME OF CEMETERY or CREMATORY <b>Mt. Calvary Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>A A County Md</b>
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1972</b>		25B. NAME OF FUNERAL DIRECTOR <b>Adolphus Halstead</b>		25C. ADDRESS <b>1206 W North Ave</b>



**FUNERAL DIRECTOR: IMPORTANT**

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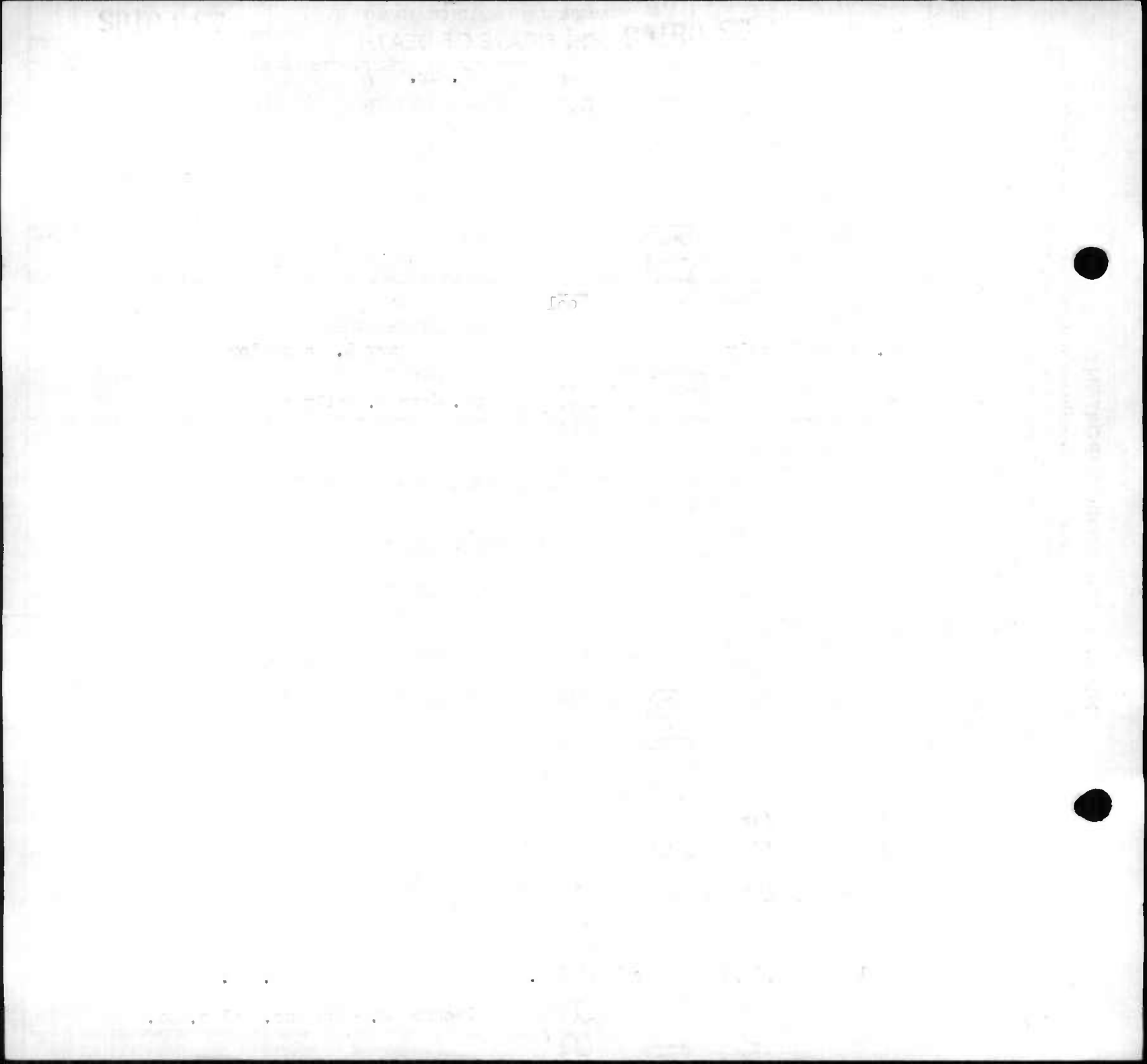
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09161
CERTIFICATE OF DEATH				STATE OF MARYLAND
BIRTH NO. <span style="float: right;">72 09161</span>		1. NAME OF DECEASED (Type or Print) <span style="float: right;">Everett R. Purkins</span>		
2. DATE AND HOUR OF DEATH		Sept. 23, 1972. 11:30 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Md. B. COUNTY Baltimore		
90 Edgewood Nursing Home		C. CITY OR TOWN Randallstown D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER 9601 Orpin Road				
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 16, 1890	9. AGE (In years last birthday) 82
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer---Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Richmond, Va.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Samuel Purkins		
14. MOTHER'S MAIDEN NAME Willie S. Holt		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 213-03-2220		17. INFORMANT Mr. Thomas E. Purkins ADDRESS (Same)		
18. 750.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac Insufficiency		
		(B) DUE TO, OR AS A CONSEQUENCE OF: Generalized Arteriosclerosis ?		
		(C) Diabetes Mellitus ?		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 7/19/72 to 9/23/72 that (I) (we) last saw the deceased alive on 8/30/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Samuel Legum MD				23B. DATE SIGNED 9/25/72
23C. PHYSICIAN'S NAME (Type) SAMUEL LEGUM MD				23D. ADDRESS Medical Arts Bldg
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/26/72		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Cem.
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 26 1972		
25B. NAME OF REGISTRAR Sidney Whiston		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md.		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

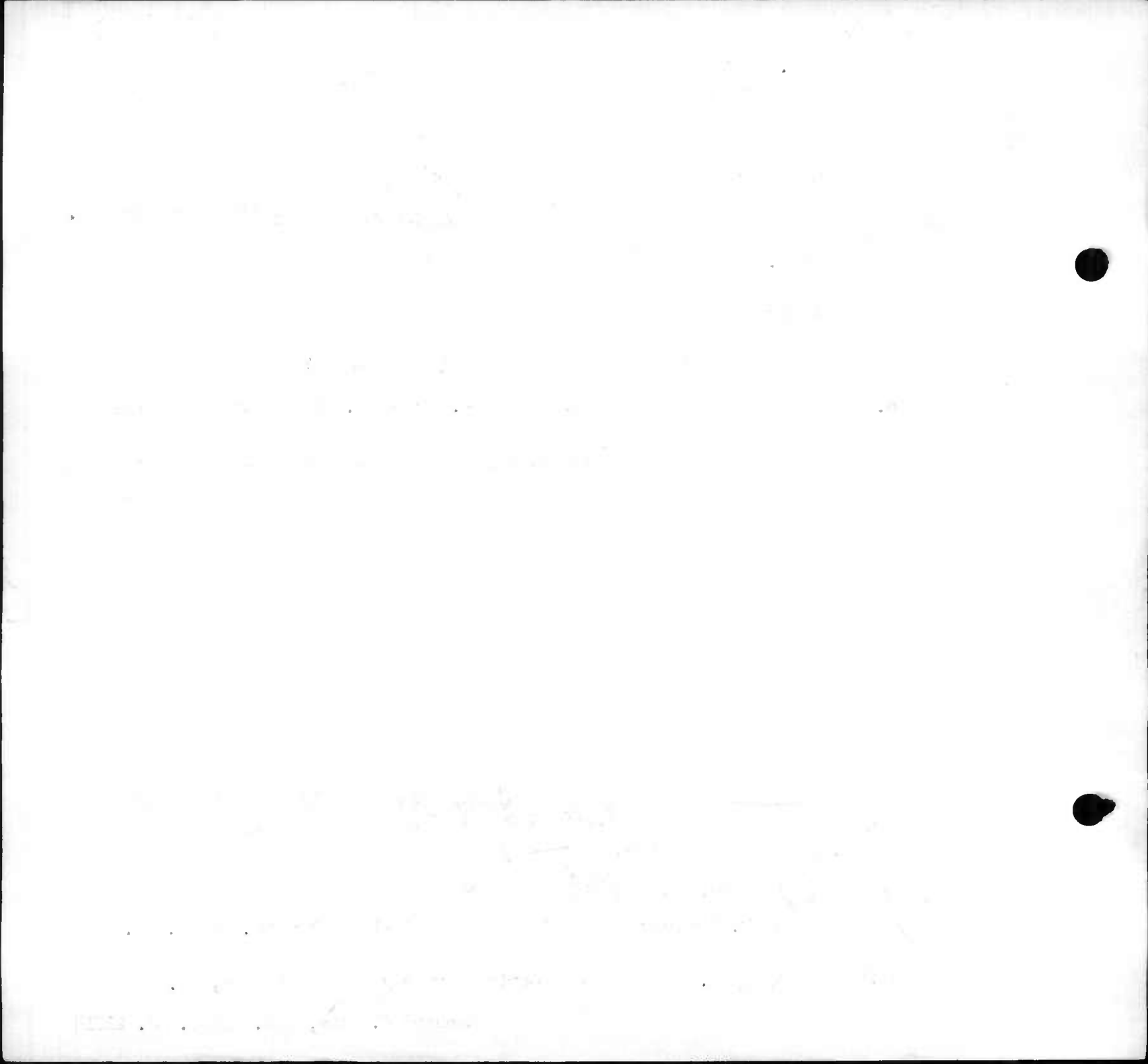
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 09162</b>
D-400		72 09162		CERTIFICATE OF DEATH
BIRTH NO.		STATE OF MARYLAND - DEATH		
1. NAME OF DECEASED (Type or Print) <b>DAILY</b>		2. DATE AND HOUR OF DEATH <b>9/23/72</b> <span style="float: right;">M. 5:30</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2734</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>8 MARYLAND Gen Hosp</b>		C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
		E. STREET AND NUMBER <b>5618 Remmell Ave</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-22-19</b>	9. AGE (In years last birthday) <b>52</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Accountant</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Elect Power Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>J. Carroll Daily</b>		
14. MOTHER'S MAIDEN NAME <b>Mary L. Batchelor</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		
16. SOCIAL SECURITY NO. <b>212-14-8743</b>		17. INFORMANT <b>Mrs. Jean R. Daily same</b>		
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Atherosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 weeks</b> <b>years</b>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes.</b>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>7/17</b> 19 <b>72</b> to <b>9/23</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Alexander Brucker MD</b>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <b>A. J. BRUCKER</b>
23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		
24B. DATE <b>9/27/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Morland Mem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1972</b>		25B. NAME OF REGISTRAR <b>Leonard J. Ruck Inc.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Balto. Md.</b>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09163	
CERTIFICATE OF DEATH				STATE OF MARYLAND-DHMH	
BIRTH NO. <b>72 09163</b>		REG. NO. <b>72 09163</b>			
1. NAME OF DECEASED (Type or Print) <b>Robert Ritmiller</b>		2. DATE AND HOUR OF DEATH <b>9/23/72</b>		11:30 am	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE <b>Maryland</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Harford Gardens Nursing Home</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
90		E. STREET AND NUMBER <b>3304 Parklawn Ave.</b>			
5. SEX <b>Male</b>	6. RACE <b>Cauc.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/27/1910</b>	9. AGE (In years last birthday) <b>62</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Butcher</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Robert Ritmiller</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth - ?</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>215-01-4065</b>		17. INFORMANT <b>Mrs. Gladys V. Ritmiller</b>	
18. <b>162-1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Squamous Cell Carcinoma of Lung</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 years</b>	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>July 21</b> 19 <b>72</b> to <b>Sept. 23</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>Sept. 22</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Loy M. Zimmerman MD</b>		23B. DATE SIGNED <b>9/23/72</b>		23C. PHYSICIAN'S NAME (Type) <b>Loy M. Zimmerman MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/26/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Md.</b>		24E. NAME OF REGISTRAR <b>Leonard P. Rack, Inc.</b>		24F. ADDRESS <b>Balto. Md. 21214</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1972</b>		25B. NAME OF REGISTRAR <b>Leonard P. Rack, Inc.</b>		25C. FUNERAL DIRECTOR <b>Leonard P. Rack, Inc.</b>	

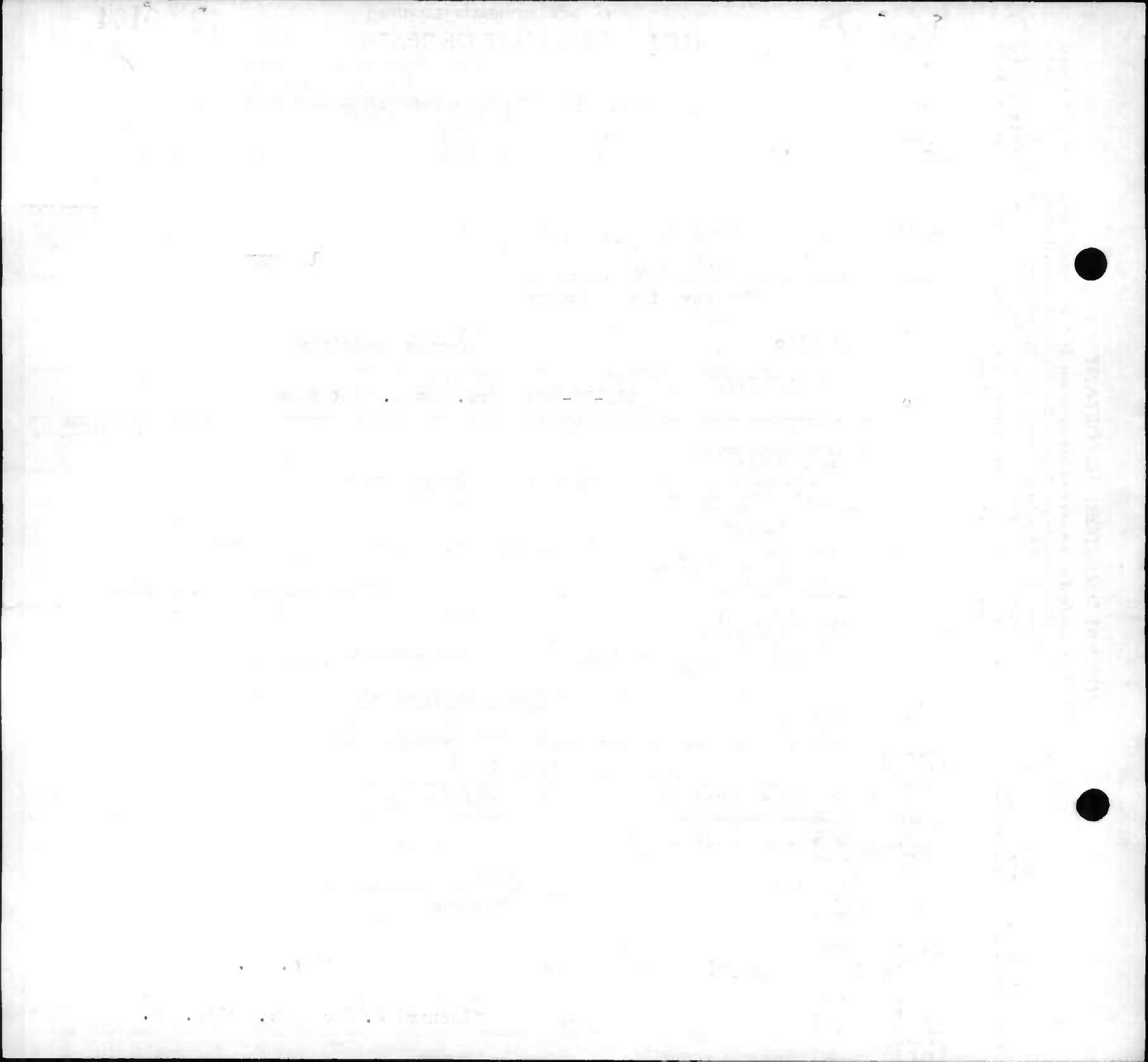




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 09164</b>	
V-300 72 09164				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Louis Vito</b>		2. DATE AND HOUR OF DEATH <b>9/24/72 5:45 AM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Maryland General Hospital</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>2825 Alvarado Square</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/5/1911</b>	9. AGE (In years last birthday) <b>61</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Key Wine &amp; Liquor</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John Vito</b>		14. MOTHER'S MAIDEN NAME <b>Jennie Suttalata</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>219-10-4204</b>		17. INFORMANT <b>Mrs. Ida M. Vito same</b>	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtemia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Circulatory and Respiratory</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Failure of central origin 12 days</b> (B) <b>Cardiac Arrhythmia, Aspiration pneumonia.</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Acute myocardial infarction 12 days</b>			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3-4 hours</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>9/13</b> 19 <b>72</b> to <b>9/24</b> 19 <b>72</b> that (1) (we) last saw the deceased alive on <b>9/24/72</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>H. Y. Y. M.D.</b>				23B. DATE SIGNED <b>9/24/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Hyo-yun YUN, M.D.</b>				23D. ADDRESS <b>Maryland General Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/27/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>					
25A. DATE ISSUED BY HEALTH DEPT. <b>SEP 26 1972</b>		25B. NAME OF FUNERAL HOME		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Balto. Md.</b>	



**FUNERAL DIRECTOR: IMPORTANT**

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 09165</b>
<b>L-520</b> <b>72 09165</b>		<b>CERTIFICATE OF DEATH</b>		
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <b>Margaret Lemke</b>		<b>2. DATE AND HOUR OF DEATH</b> <b>9/24/72</b> <b>4:15 A.M.</b>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 827 N. Kenwood Ave.</b>		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>701</b> <b>5. CITY OR TOWN</b> <b>Baltimore</b> <b>6. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>7. STREET AND NUMBER</b> <b>827 N. Kenwood Ave.</b>		
<b>5. SEX</b> <b>F.</b>	<b>6. RACE</b> <b>W.</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>6/6/1893</b>	<b>9. AGE</b> (In years last birthday) <b>79</b> <b>10. Under 1 Yr. Months</b> <b>11. Under 24 Hrs. Days</b> <b>12. Under 24 Hrs. Hours</b> <b>13. Under 24 Hrs. Min.</b>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>		
<b>13. FATHER'S NAME</b> <b>Christian Schmidt</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Marguritte Unknown</b>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>216-03-3438</b> <b>17. INFORMANT</b> <b>Mr. George Lemke</b> <b>ADDRESS</b> <b>Same</b>		
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>19. ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Coronary Thrombosis</b> (B) <b>Arteriosclerotic C-V Disease</b> (C)		
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>				
<b>19A. DATE OF OPERATION</b> <b>0</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <b>3/20</b> <b>1948</b> <b>to</b> <b>9/24</b> <b>1972</b> , that (I) <del>was</del> lost saw the deceased alive on <b>9/5</b> <b>1972</b> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) <del>did not</del> view the body after death.				
<b>23A. SIGNATURE</b> <b>L.B. Stevens</b>		<b>23B. DATE SIGNED</b>		<b>23C. PHYSICIAN'S NAME</b> (Type) <b>L.B. Stevens</b> <b>23D. ADDRESS</b> <b>3400 Erdman Ave. Balto. Md.</b>
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>24B. DATE</b> <b>9/27/72</b>		<b>24C. NAME OF CEMETERY OR CREMATORY</b> <b>Lorraine Park Cemetery</b> <b>24D. LOCATION</b> (City, town, or county) (State) <b>Baltimore Maryland</b>
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>SEP 26 1972</b>		<b>25B. NAME OF REGISTRAR</b> <b>Leonard G. Buck Inc.</b>		<b>25C. FUNERAL DIRECTOR</b> <b>Leonard G. Buck Inc. Balto. Md.</b>

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPT.				REG. NO. 72 09166	
G-652 72 09166 CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <b>Anna Helen Greensfelder</b>			2. DATE AND HOUR OF DEATH <b>Sept. 24, 1972 3:20 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 3014 Christopher Ave</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2745</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3014 Christopher Ave</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 28, 1910</b>		9. AGE (In years last birthday) <b>61</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cashier</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Senator Theater</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Charles O Brunn</b>		
14. MOTHER'S MAIDEN NAME <b>Emma Schlegel</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>220-44-9446</b>			17. INFORMANT <b>Mrs Jacqueline Nilsen</b>		
18. <b>174X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>Melanotic Cancer</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Breast Carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>months</b> <b>years</b>			19. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <b>0</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</b> <b>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</b> <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location) <b>21D. TIME OF INJURY (Month) (Day) (Year) (Hour)</b> <b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> <b>21F. HOW DID INJURY OCCUR?</b>		
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Gracito V. Patricio</b>			23B. DATE SIGNED <b>9/25/72</b>		23C. PHYSICIAN'S NAME (Type) <b>Gracito V. Patricio</b>
23D. ADDRESS <b>4508 Harford Rd Baltimore, Md</b>			24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		
24B. DATE <b>9/27/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1972</b>			25B. NAME OF REGISTRAR <b>Sidney H. [Signature]</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Baltimore, Md</b>

SHEET (44) 200000

1:50,000 Scale

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3. Summary

4. Conclusions

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6. Appendix

7. Notes

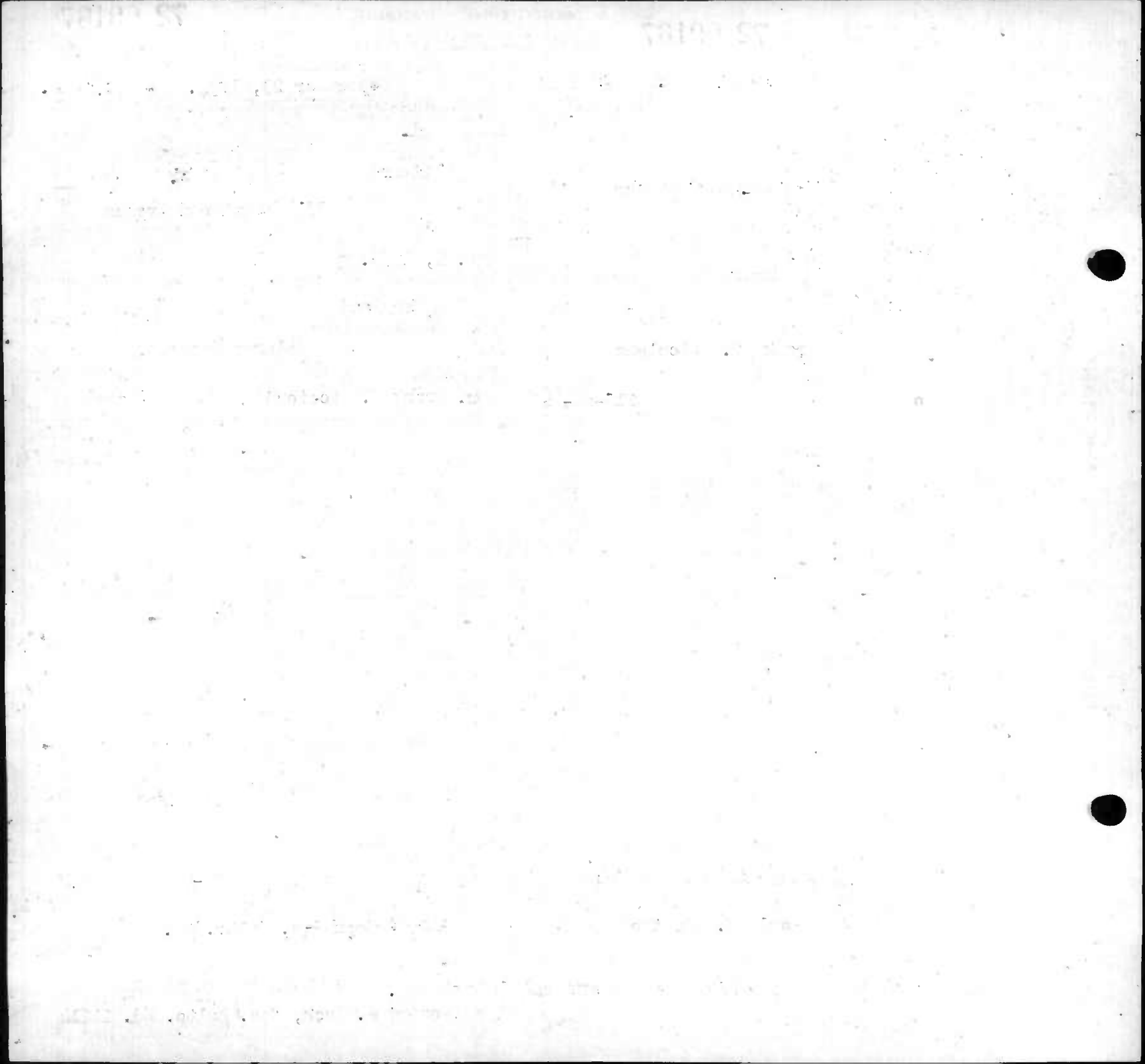
8. Bibliography

9. Index

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-250		72 09167		BALTIMORE CITY HEALTH DEPARTMENT		72 09167	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
PATRICIA ANN PICCIONE				September 23, 1972. 7:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE Md.		B. COUNTY	
00 3774 Ravenwood Avenue				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER				3774 Ravenwood Avenue			
5. SEX Female		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 2, 1955.	
9. AGE (In years last birthday) 17		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank V. Piccione				14. MOTHER'S MAIDEN NAME Delores Young			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-66-9433		17. INFORMANT Mr. Frank V. Piccione		ADDRESS (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE Osteogenic Sarcoma DUE TO, OR AS A CONSEQUENCE OF  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____			
19. DATE OF OPERATION				20. AUTOPSY? (Yes or No)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3-5-1957 to 9-23-1972, that (I) (we) last saw the deceased alive on 9-22-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE Paul H. Anniko			
23B. DATE SIGNED 9-25-72				23C. PHYSICIAN'S NAME (Type) Paul H. Anniko MD			
23D. ADDRESS 3800 Erdman Ave. Balto. Md.				24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 9/27/72				24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cem.			
24D. LOCATION (City, town, or county) (State) Baltimore Maryland				25A. DATE REC'D BY HEALTH DEPT. SEP 26 1972			
25B. NAME OF REGISTRAR Sidney H. Hinton				25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214			





STATE OF MARYLAND-DEMH BALTIMORE CITY HEALTH DEPARTMENT			
B-652 72 09168		MEDICAL EXAMINER'S CERTIFICATE OF DEATH	
BIRTH NO.		REG. NO. 72 09168	
1. NAME OF DECEASED (Type or Print) <b>CHARLES H. BRINKMEYER</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> <b>September 21, 1972</b> Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL or INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2607 Dulaney Street</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>September 21, 1972 3:45 P.</b> M.	
6. SEX <b>Male</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE <b>White</b>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2005</b>	
9. DATE OF BIRTH <b>Feb. 15, 1884</b>		10. AGE (In years lost birthday) <b>88</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Car Inspector Penn. Railroad</b>		13. FATHER'S NAME <b>William Brinkmeyer</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		15. MOTHER'S MAIDEN NAME <b>Barbara Dill</b>	
17. SOCIAL SECURITY NO. <b>717-07-7332</b>		18. INFORMANT ADDRESS <b>Mrs. Mildred Hutchins 2607 Dulaney St.</b>	
19. <b>412.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Marvin S. Platt, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>9/22/72</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Sept. 23, 1972</b>	
24C. NAME of CEMETERY or CREMATORY <b>Lorraine Park Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1972</b>		25B. NAME OF REGISTRAR <b>Lidney</b>	
25C. FUNERAL DIRECTOR <b>G. Truman Schwab</b>		ADDRESS <b>3512 Frederick Ave.</b>	

75 0013

1975 12 17

1975 12 17

William H. Harkness

Barbara Hill

1975 12 17 1975 12 17 1975 12 17

1975 12 17 1975 12 17 1975 12 17

1975 12 17 1975 12 17 1975 12 17

1975 12 17 1975 12 17 1975 12 17

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-543		72 09169		BALTIMORE CITY HEALTH DEPARTMENT		72 09169		
CERTIFICATE OF DEATH				REG. NO.				
1. NAME OF DECEASED (Type or Print) <u>Florence Hamilton</u>				2. DATE AND HOUR OF DEATH <u>9/23/72</u> <u>5:40 P.M.</u>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>Lutheran Hospital of Md.</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>md</u> B. COUNTY <u>1547</u>				
				C. CITY OR TOWN <u>BALTO</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
				E. STREET AND NUMBER <u>3035 Windsor Ave</u>				
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-8-98</u>		9. AGE (In years last birthday) <u>74</u>	10. If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>- ?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>NO</u> If yes, give war or dates of service		16. SOCIAL SECURITY NO. <u>216-32-8938</u>		17. INFORMANT <u>CHART</u> ADDRESS				
18. <u>412.31 + 250.9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH  (A) IMMEDIATE CAUSE <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF:  (B) <u>Shock Infection</u> DUE TO, OR AS A CONSEQUENCE OF:  (C) <u>Cholestatic Jaundice</u>  <u>GI Bleeding Cause Unknown</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).								
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>8-14</u> 19 <u>72</u> to <u>9-23</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>9-23</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.								
23A. SIGNATURE <u>LOURDES M. VICTORIA MD</u>				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>LOURDES M. VICTORIA MD</u>		
23D. ADDRESS <u>Lutheran Hospital of Maryland</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>						
24B. DATE <u>9/25/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>CORRAINE</u>		24D. LOCATION <u>BALTO. MD.</u>		24E. CITY, TOWN, OR COUNTY (State)		
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 26 1972</u>		25B. NAME OF REGISTRAR <u>David W. ...</u>		25C. FUNERAL DIRECTOR <u>Paul E. ...</u>		25D. ADDRESS <u>3617 ... Ave.</u>		

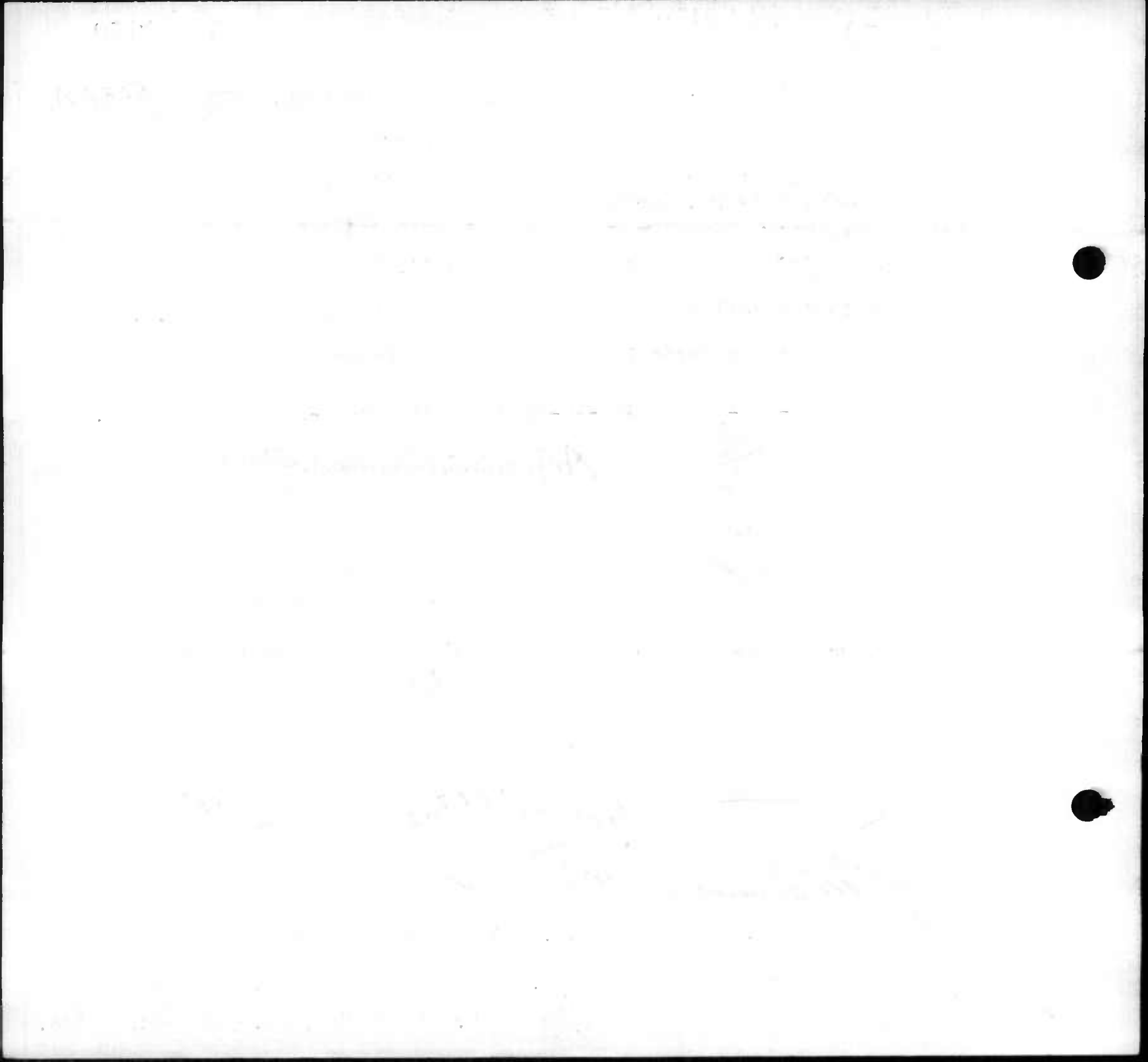
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FUNERAL DIRECTOR: IMPORTANT

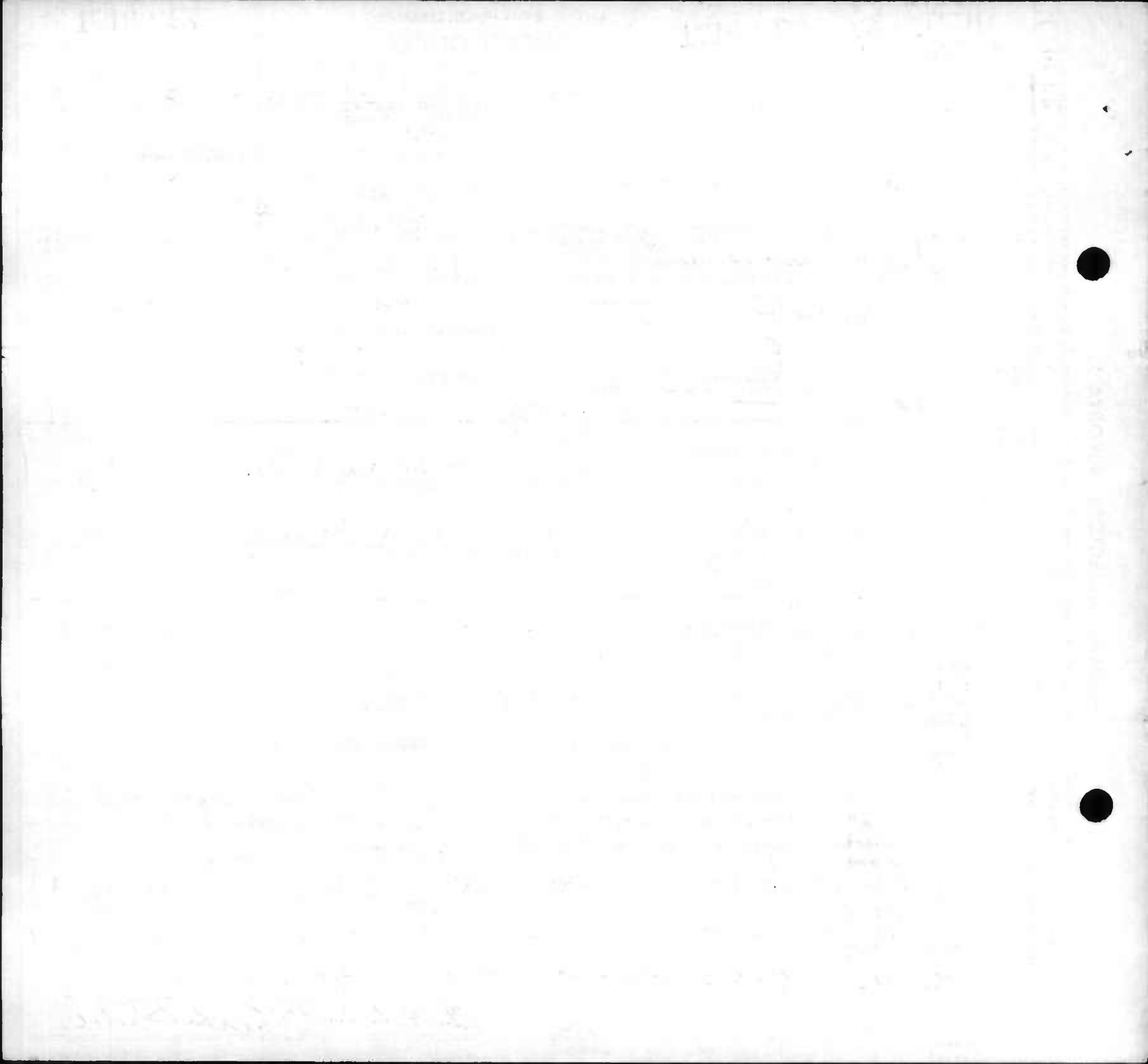
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-250		72 09170		BALTIMORE CITY HEALTH DEPARTMENT		72 09170	
CERTIFICATE OF DEATH				REG. NO.			
1. NAME OF DECEASED (Type or Print) <b>Mable V. Beckham</b>				2. DATE AND HOUR OF DEATH <b>Sept 24, 1972</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>00</b> 216 Ridgewood Road Baltimore, Maryland				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2714</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>216 Ridgewood Road</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar 21, 1885</b>		9. AGE (In years last birthday) <b>87 yrs</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Saleslady</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>
13. FATHER'S NAME <b>James Van Arsdell</b>				14. MOTHER'S MAIDEN NAME <b>McCoun</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-14-7120</b>		17. INFORMANT <b>Robert P John-216 Ridgewood Rd.</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardio-vascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF: <b>(A) IMMEDIATE CAUSE</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Several years</b>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>II</b>							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1967</b> to <b>Sept. 24, 1972</b> that (I) (we) lost saw the deceased alive on <b>Sept. 22, 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Loy M. Zimmerman M.D.</b>				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <b>Loy M. Zimmerman M.D.</b>	
23D. ADDRESS <b>3202 Harford Road</b>				23E. FUNERAL DIRECTOR <b>A. Alan Seltz, Jr.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/25/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Lorraine Pk. Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1972</b>				25B. NAME of REGISTRAR <b>Andrew Johnson</b>			
25C. ADDRESS <b>3818 Roland Ave.</b>				25D. ADDRESS <b>3818 Roland Ave.</b>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09171	
C-534 72 09171				72 09171	
CERTIFICATE OF DEATH				REG. NO.	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Audrey J. Chandler		September 24, 1972 4:45 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
Md. General Hospital				Md. 1207	
48				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER					
426 Fawcett St.					
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
FEMALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9-2-22	50	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				MD.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
?		?		U.S.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		215-16-1526		chart.	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
I					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				3 days	
Medullary Failure					
(B) DUE TO, OR AS A CONSEQUENCE OF:				3 days	
intra cranial hemorrhage					
(C)					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				2 yrs.	
Hypertensive cardiovascular disease					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from September 21, 1972 to September 24, 1972 that (I) (we) last saw the deceased alive on September 24, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Harry A. Spalt MD				9/24/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
HARRY A. SPALT MD				Md. General Hospital Baltimore MD 21207	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
BURIAL		9/28/72		GARDENS OF ETERNAL HOME	
				FINKSBURG, MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
SEP 26 1972		Audrey J. Chandler		Paul E. Chandler 3512 Ashland Ave.	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09172		STATE OF MARYLAND-DMH	
BIRTH NO. 72 09172				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Margaret R. Becraft</b>				2. DATE AND HOUR OF DEATH <b>9/23/72 8:30 P.</b> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2738 Huntingdon Ave.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1207</b>			
5. SEX <b>Female</b>		6. RACE <b>Cauc.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/9/89</b> 9. AGE (In years last birthday) <b>83</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>?</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
13. FATHER'S NAME <b>?</b>				14. MOTHER'S MAIDEN NAME <b>?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no 213-74-5166</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Laura V. Brooks (same)</b> ADDRESS	
18. <b>4/2.3 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arterio Sclerotic Heart Disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <b>Generalized Arterio Sclerotic</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Arterio Sclerotic Heart Disease</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Generalized Arterio Sclerotic</b> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Semile Psychosis</b>							
19A. DATE OF OPERATION <b>None</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Sept. 21st 1972</b> to <b>Sept. 23 1972</b> , that (I) <del>was</del> lost saw the deceased alive on <b>Sept. 22- 1972</b> and that in (my) <del>last</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> <del>did</del> (did not) view the body after death.							
23A. SIGNATURE <b>Earl L. Chambers M.D.</b> DEGREE				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>9/25/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Earl L. Chambers - M.D.</b> DEGREE				23D. ADDRESS <b>100-W. Cold Spring Balto. Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/26/72</b>		24C. NAME OF CEMETERY or CREMATOR <b>Oella</b>		24D. LOCATION (City, town, or county) (State) <b>Catonsville, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1972</b>				25B. NAME OF REGISTRAR <b>Paul E. Chenoweth</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Paul E. Chenoweth 3rd 3617 Chestnut Ave.</b>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased at final disposition is made. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-650 72 09173		BALTIMORE CITY HEALTH DEPARTMENT		72 09173	
BIRTH NO. 72-13811		CERTIFICATE OF DEATH		REG. NO. STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print) <b>BRUNE, BABY GIRL</b>		Christina Lynn Brune		2. DATE AND HOUR OF DEATH <b>SEPTEMBER 20, 1972 2:00 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>ST AGNES HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE COUNTY</b> C. CITY OR TOWN <b>Dundalk</b> D. INSIDE CITY LIMITS? <b>BALTIMORE</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>4146 BEECHWOOD ROAD 21222</b>		5300	
5. SEX <b>FEMALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>09-19-72</b>	9. AGE (In years last birthday) <b>13</b>	If Under 1 Yr. Months: Days: <b>13 5</b> If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>LOUIS T. BRUNE</b>		14. MOTHER'S MAIDEN NAME <b>(MASON) LINDA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>RECORD'S BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS &amp; CATON AVE</b>	
18. <b>7777 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Prematurity</b> (B) <b>Premature delivery at 22 weeks gestation.</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>XX</del> (this hospital) attended the deceased from <b>SEPTEMBER 19, 1972</b> to <b>SEPTEMBER 20, 1972</b> , that <del>X</del> (we) last saw the deceased alive on <b>SEPTEMBER 20, 1972</b> and that in <del>XX</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>(X)</del> (We) (did) <del>XXXX</del> view the body after death.					
23A. SIGNATURE <b>L. Pallan</b>		23B. DATE SIGNED <b>9/21/72</b>		23C. PHYSICIAN'S NAME (Type) <b>LIZZY PALLAN</b>	
23D. ADDRESS <b>BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS &amp; CATON AVE</b>		23E. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1972</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/23/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart of Jesus</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		24E. NAME OF REGISTRAR <b>John J. Duda</b>		24F. FUNERAL DIRECTOR <b>7922 Wise Ave. Dundalk, Md.</b>	

DEPT. OF HEALTH

MARYLAND

ST. JOSEPH HOSPITAL

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LOUISIANA

ST. JOSEPH HOSPITAL

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ST. JOSEPH HOSPITAL

RECEIVED

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09174	
7-231 72 09174				STATE OF MARYLAND-DEPT	
BIRTH NO.				DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Edward G. Foster</b>				2. DATE AND HOUR OF DEATH <b>9-22-72 6:40 AM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>CHURCH HOME &amp; HOSPITAL, BALTO MD</b>				A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
				C. CITY OR TOWN <b>Dundalk</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <b>7100 MAPLE DRIVE</b>	
5. SEX <b>MALE</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-04-99</b>		9. AGE (In years last birthday) <b>72</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BETHLEHEM STEEL</b>			11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>WILLIAM FOSTER</b>			14. MOTHER'S MAIDEN NAME <b>LENA McGARY</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-07-9133</b>	17. INFORMANT <b>Wife: Mrs. Annie L. Foster</b> ADDRESS <b>7100 Maple Drive Dundalk, Md. 21222</b>		
18. <b>412.34-250.9</b> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>ON &amp; OFF</b>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE <b>CONGESTIVE HEART FAILURE FOR YRS</b>	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES				(B) <b>A.S.H.D.</b>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO, OR AS A CONSEQUENCE OF:	
II				(C) _____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				<b>DIABETES MELLITUS</b>	
19A. DATE OF OPERATION <b>None</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9-7-72</b> 19 to <b>9-22-72</b> 19 that (I) (we) last saw the deceased alive on <b>9-22-72</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Bernard Yukna MD</b> DEGREE				23B. DATE SIGNED <b>9-22-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>BERNARD YUKNA MD</b> DEGREE				23D. ADDRESS <b>CHURCH HOME &amp; HOSP BALTO</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-24-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Confederate Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Spotsylvania, Virginia</b>		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1972</b>		25B. NAME OF REGISTRAR <b>Lidney Wilson</b>		25C. FUNERAL DIRECTOR <b>John J. Duda</b> ADDRESS <b>7922 Wise Ave. Dundalk, Md. 21222</b>	



1		STATE OF MARYLAND - DHMH BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 72 09175	
BIRTH NO.							
1. NAME OF DECEASED (Type or Print) Frank J. MYSLINSKI				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year Hour September 21, 1972 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1436 Dundalk Avenue				3. DATE PRONOUNCED DEAD Month Day Year Hour September 21, 1972 1:10 A. M.			
6. SEX Male				7. RACE White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 12-28-02				10. AGE (In years last birthday) 69		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME John F. Myslinski		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
15. MOTHER'S MAIDEN NAME Stella Moniewski				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 214-03-3194	
18. INFORMANT Mrs. Anna R. Myslinski				19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE: Marvin S. Platt, M.D. DATE SIGNED: September 21, 1972 EXAMINER'S NAME (Type):							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-25-72		24C. NAME of CEMETERY or CREMATORY St. Stanislaus Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 26 1972		25B. NAME OF REGISTRAR John J. Duda		25C. FUNERAL DIRECTOR John J. Duda		ADDRESS 2829 Hudson St. Balto. Md. 21224	



25 1915

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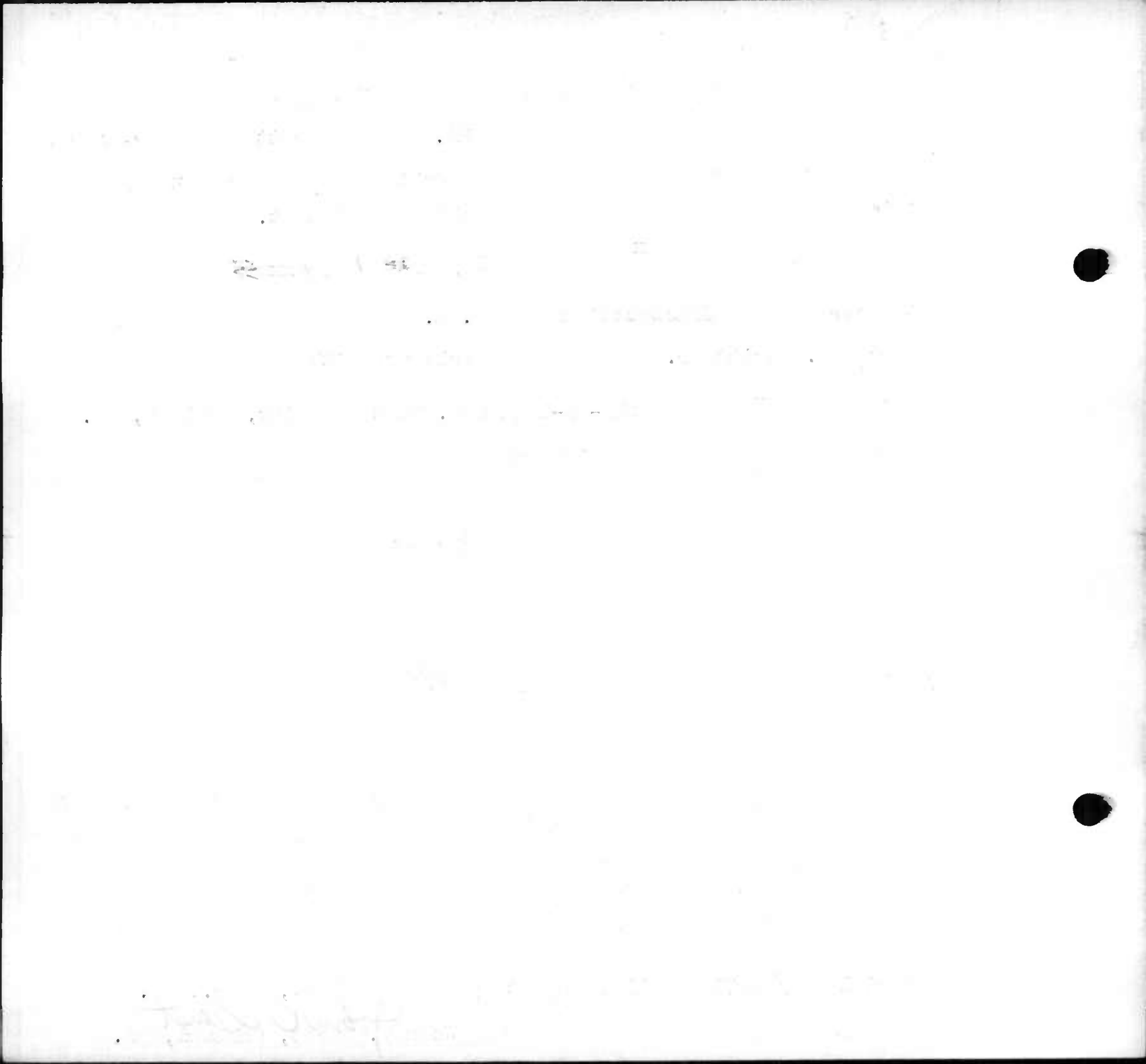




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-300		BALTIMORE CITY HEALTH DEPARTMENT		72 09176	
BIRTH NO.		72 09176		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		DeWitt, Porter E.		REG. NO. 72 09176	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		6. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		STATE OF MARYLAND - DEPT. OF HEALTH	
FULL NAME OF HOSPITAL OR INSTITUTION <i>University of Maryland Hospital</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Md. B. COUNTY Garrett	
5. SEX <i>M</i>		6. RACE <i>W</i>		C. CITY OR TOWN Oakland	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 12/25/17		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		E. STREET AND NUMBER 611 East High St.	
Laborer		Construction		11. BIRTHPLACE (State or foreign country) W. Va.	
13. FATHER'S NAME Porter E. DeWitt Sr.		14. MOTHER'S MAIDEN NAME Zula Griffith		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-03-1944		17. INFORMANT Mrs. Porter DeWitt, Oakland, Md.	
Yes WW II		18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		1 mo.	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE		with Metastasis Thoracic Spine	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO, OR AS A CONSEQUENCE OF:		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:		(D) DUE TO, OR AS A CONSEQUENCE OF:	
19A. DATE OF OPERATION 1 9/2/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Metastasis Thoracic Spine		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		22. I certify that (I) (this hospital) attended the deceased from August 31 19 72 to Sept 21 19 72		that (I) (we) last saw the deceased alive on Sept 21 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE J. H. Ziegler M.D.		23B. DATE SIGNED 9/21/72		23C. PHYSICIAN'S NAME (Type) J. H. Ziegler M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/23/72		24C. NAME OF CEMETERY OR CREMATORY Oakland Cemetery	
25A. DATE REC'D BY HEALTH DEPT. SER 26 1972		25B. NAME OF REGISTRAR Sidney H. Hinton		25C. FUNERAL DIRECTOR John O. Durst	
26A. ADDRESS		26B. ADDRESS		26C. ADDRESS	
University of Maryland Hospital		University of Maryland Hospital		Oakland, Garr., Md.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 09177</u>	
M-600 72 09177				STATE OF MARYLAND-DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>MOORE, EDITH B.</u>		2. DATE AND HOUR OF DEATH <u>9.21.1972</u> <u>10.15 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>U.S.A.</u>		1348	
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNION MEMORIAL HOSPITAL</u> <u>44</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>1416 BERRY STREET</u>		5. SEX <u>F</u> 6. RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>05-16-18</u> 9. AGE (In years last birthday) <u>54</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WAITRESS</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>FLOYD ROSS</u>		14. MOTHER'S MAIDEN NAME <u>LENA BISH</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212 16 5201</u>		17. INFORMANT <u>HAROLD L. MOORE</u>	
ADDRESS <u>SAME</u>		18. <u>676.0 I</u> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>PULMONARY EMBOLISM</u>		<u>3 DAYS</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>PELVIC INFLAMMATORY DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>1 MONTH</u>	
(C) <u>D.C.</u>				<u>1 MONTH</u>	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>09/18/72</u> 19 <u>72</u> to <u>09/21/</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>09/21</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>09.21.72.</u>		23C. PHYSICIAN'S NAME (Type) <u>[Signature]</u>	
23D. ADDRESS <u>[Signature]</u>		23E. NAME OF REGISTRAR <u>[Signature]</u>		23F. FUNERAL DIRECTOR <u>[Signature]</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Entombment</u>		24B. DATE <u>25 Sept 72</u>		24C. NAME of CEMETERY or CREMATORY <u>Dulaney Valley Mem. Gardens</u>	
24D. LOCATION (City, town, or county) (State) <u>Cockeysville, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 26 1972</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>	
25C. FUNERAL DIRECTOR <u>[Signature]</u>		25D. ADDRESS <u>[Signature]</u>		25E. NAME OF REGISTRAR <u>[Signature]</u>	

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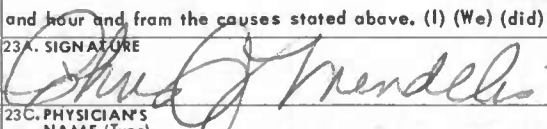

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 09178</b>	
K-561 72 09178				STATE OF MARYLAND-DISTRICT	
BIRTH NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>ELIZABETH M. KENNERUP</b>				September 22, 1972   <b>11:30</b> A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 304 S. Catherine Street Baltimore, Maryland 21223</b>				A. STATE <b>Maryland</b> B. COUNTY	
				C. CITY OR TOWN <b>Baltimore</b>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>304 S. Catherine Street 21223</b>	
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9- 2- 1889</b>	9. AGE (In years last birthday) <b>83</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>Henry Wagener</b>			14. MOTHER'S MAIDEN NAME <b>Rosina Wagener</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>213-74-8997</b>		17. INFORMANT ADDRESS <b>Miss Marie Wagener, 304 S. Catherine St. 21223</b>
18. <b>412.2.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>H.C.V.D.</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Sept. 1</b> 19 <b>60</b> to <b>Sept. 22</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>Sept. 22</b> 19 <b>72</b> and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED <b>9/23/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Christopher J. Mendelis M.D.</b>				23D. ADDRESS <b>2308 Edmondson Avenue, Balto., Md. 21223</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-26-1972</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1972</b>		25B. NAME OF REGISTRAR 		25C. FUNERAL DIRECTOR ADDRESS <b>Howard H. Hubbard, 4107 Wilkens Ave 21229</b>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 09179		72 09179	
BIRTH NO. <u>M-216</u>		72 09179		REG. NO. <u>STATE OF MARYLAND-DHMH</u>	
1. NAME OF DECEASED (Type or Print) <b>MC KEEVER, EARL FRANCIS</b>			2. DATE AND HOUR OF DEATH <b>September 23, 1972 8:30 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>102</b>		
5. SEX <b>MALE</b>			6. RACE <b>CAUCASIAN</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Inactive</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>National Brewery</b>		8. DATE OF BIRTH <b>8/24/13</b>
11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>			9. AGE (In years last birthday) <b>59</b>		
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>LOUIS L. MC KEEVER</b>		
14. MOTHER'S MAIDEN NAME <b>ANNA CROSSLAND</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>		
16. SOCIAL SECURITY NO. <b>188-07-0728</b>			17. INFORMANT <b>Mrs. Dorothy V. McKeever, 2231 Annapolis Rd. CLIN RCDS, VAH BALTIMORE, MARYLAND 21218</b>		
18. <b>195.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>CARDIO-PULMONARY ARREST</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>METASTATIC SQUAMOUS CELL CARCINOMA OF HEAD AND NECK</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immed</b> <b>2 mos.</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>08/25/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CERVICAL LYMPH NODE BIOPSY</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>XX</b> (this hospital) attended the deceased from <b>August 22,</b> 19 <b>72</b> to <b>16</b> September 23, 1972 that <b>X</b> (we) last saw the deceased alive on <b>September 23,</b> 19 <b>72</b> and that in <b>XX</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>XX</b> (We) (did) <b>XXXX</b> view the body after death.					
23A. SIGNATURE <i>Alan G. Stahl, M.D.</i>				23B. DATE SIGNED <b>9/23/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>ALAN G. STAHL, M.D.</b>				23D. ADDRESS <b>VA HOSPITAL, BALTIMORE, MARYLAND 21218</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-26-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Finksburg Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Finksburg, Maryland</b>		25A. DATE RECEIVED BY HEALTH DEPT. <b>SEP 26 1972</b>			
25B. NAME OF REGISTRAR <b>HUBBARD FUNERAL HOME</b>		25C. FUNERAL DIRECTOR ADDRESS <b>4107 Wilkens Ave Baltimore, Md.</b>			



RECEIVED

U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535

DATE: 10/1/73

TO: DIRECTOR

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

100-111111

RE: [Illegible]

REFERENCE IS MADE TO [Illegible]

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10/1/73 BY [Illegible]

U.S. DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF INVESTIGATION

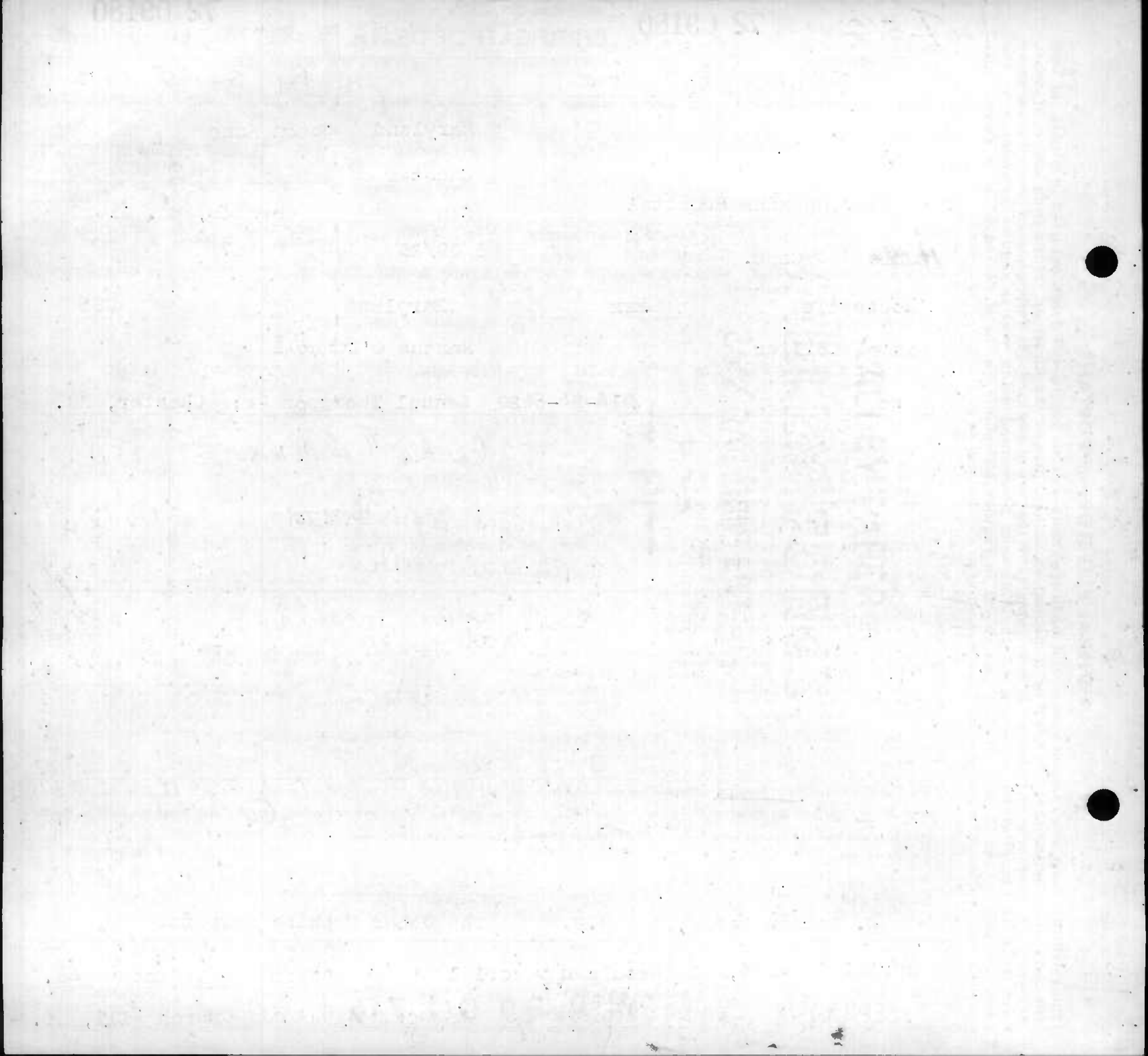
WASHINGTON, D.C. 20535



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

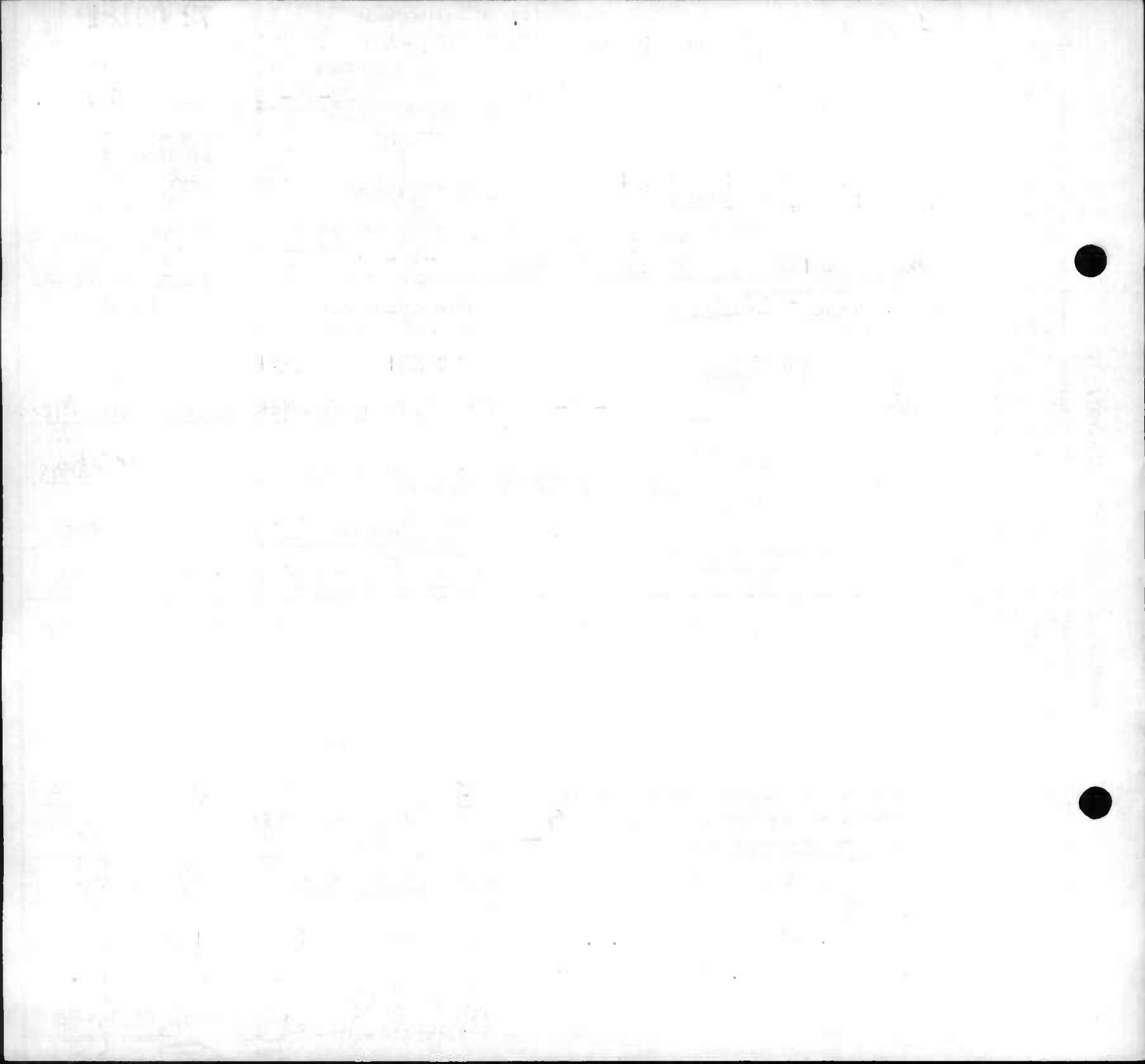
T-512		72 09180		BALTIMORE CITY HEALTH DEPARTMENT		72 09180	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.		STATE OF MARYLAND-DEATH	
1. NAME OF DECEASED (Type or Print)		Thompson, Betty Jane		2. DATE AND HOUR OF DEATH		2:10 AM Sept 18, 1972 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		Maryland Queen Anne		6700	
FULL NAME OF HOSPITAL OR INSTITUTION 33		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
The Johns Hopkins Hospital		Box		Chester, Md. 21619			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 Yr. Months: Days	10. UNDER 24 Hrs. Hours: Min.	
Female	Cauc.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	5/09/25	47			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		xxx		Maryland		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
Samuel Collier		Martha O'Donnell					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
no		214-24-6420		Lemuel Thompson Jr;		Chester, Md.	
18. 563.1 I		CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		Cardiac Arrhythmia				25 min.	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES		Prolonged Sepsis				10 days	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:					
		ulcerative colitis				7 years	
II		Renal Failure Pneumonia					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Bleeding Diathesis					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
19/11/72	Intraabdominal Abscesses	No					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?					
	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>						
22. I certify that (I) (this hospital) attended the deceased from Sept 11 19 72 to Sept 18 19 72, that (I) (we) last saw the deceased alive on Sept 18 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE		23B. DATE SIGNED			
J. Lucian Davis		Sept 18, 1972					
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS					
J. Lucian Davis, M.D.		The Johns Hopkins Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)	(State)			
Burial	Sept, 21	Woodlawn Memorial	Easton	Talbot		Md.	
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS				
SEP 26 1972	Andrew J. ...	Belgic ... Lane	Church Hill, Md.				



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09181		REG. NO.	
BIRTH NO. 14-460				72 09181			
1. NAME OF DECEASED (Type or Print) EDWARD JOSEPH HILLYER				2. DATE AND HOUR OF DEATH 09-17-72 10:25A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY KENT			
FULL NAME OF HOSPITAL OR INSTITUTION 3 THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205				C. CITY OR TOWN ROCK HALL			
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX MALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 01-25-09	
9. AGE (in years last birthday) 63		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE-COLLEGE				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME CHARLES HILLYER			
14. MOTHER'S MAIDEN NAME BARRIE PAULSTICH				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 219-01-8085				17. INFORMANT MRS. ESTHER HILLYER-ROCK HALL, MD.			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 39-9-72 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED RUPTURED AORTIC ANEURYSM 20A. AUTOPSY? (Yes or No) YES 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? CARDIORESPIRATORY INSUFFICIENCY 6 DAYS PROLONGED SHOCK STATE 7 DAYS RUPTURED AORTIC ANEURYSM 8 DAYS RENAL FAILURE COAGULOPATHY 5-6 DAYS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 9-3 1972 to 9-17 1972 that (I) (we) last saw the deceased alive on 9-17 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE W. Sindelar M.D. 23B. DATE SIGNED 9-17-72			
23C. PHYSICIAN'S NAME (Type) W. SINDELAR M.D.				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE Sept. 20			
24C. NAME OF CEMETERY OR CREMATORY Wesley Chapel				24D. LOCATION (City, town, or county) (State) Rock Hall Kent Md.			
25A. DATE REC'D BY HEALTH DEPT. SEP 26 1972				25B. NAME OF REGISTRAR Alicia R. Lane			
25C. FUNERAL DIRECTOR Church Hill, Md				25D. ADDRESS			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-532		72 09182		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09182	
BIRTH NO.		72 09182		CERTIFICATE OF DEATH		STATE OF MARYLAND-DEATH	
1. NAME OF DECEASED (Type or Print)		KUNTZ, WALTER		2. DATE AND HOUR OF DEATH		September 9, 1972 2:10 A.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218				Penna. Penna. V35			
5. SEX Male		6. RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-22-92	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Adonas Kuncas				14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 6-30-18 to 8-6-19		16. SOCIAL SECURITY NO. 188-36-0199		17. INFORMANT Records V. A. Hospital 3900 Loch Raven Blvd., Baltimore, Md. 21218			
18. 038.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II (MYOCARDIAL INFARCTION OLD AND NEW) LEFT VENTRICULAR ANEURYSM				CAUSE OF DEATH (A) IMMEDIATE CAUSE SEPSIS DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> At Work		21F. HOW DID INJURY OCCUR?			
22. I certify that 10 (this hospital) attended the deceased from September 6, 19 72 to September 9, 19 72, that 11 (we) last saw the deceased alive on September 9, 19 72 and that in 12 (my) (our) opinion death occurred on the date and hour and from the causes stated above. 10 (We) (did) (did not) view the body after death.							
23A. SIGNATURE Lawrence A. Fleming M.D.				23B. DATE SIGNED 9/12/72		23C. PHYSICIAN'S NAME (Type) LAWRENCE A. FLEMING, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE Sept. 19		24C. NAME OF CEMETERY OR CREMATORY Holy Sepulchre	
25A. DATE REC'D BY HEALTH DEPT. SEP 26 1972				25B. NAME OF REGISTRAR Anthony R. Kane		25C. FUNERAL DIRECTOR Anthony R. Kane	
26A. LOCATION (City, town, or county) Montgomery CO.				26B. ADDRESS (State) Penna.			

9/10/57

RECEIVED - 9/10/57

9/11/57

RECEIVED - 9/11/57



STATE OF MARYLAND - DHMH BALTIMORE CITY HEALTH DEPARTMENT									
72 09183 MEDICAL EXAMINER'S CERTIFICATE OF DEATH					REG. NO. 72 09183				
BIRTH NO.									
1. NAME OF DECEASED (Type or Print) <u>John Phillip Prell</u>					2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <u>9 22 '72</u>				
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>Johns Hopkins Hospital</u>					3. DATE PRONOUNCED DEAD Month Day Year Hour <u>9 22 72 9:24 p.</u>				
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>BALTO</u>									
6. SEX <u>male</u>		7. RACE <u>White</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <u>Balto.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <u>Apr. 18, 1910</u>		10. AGE (In years last birthday) <u>62</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		E. STREET AND NUMBER <u>7201 Shadowlawn Avenue</u>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Utility Operator</u>					14B. KIND OF BUSINESS OR INDUSTRY <u>Continental Can Co.</u>		15. MOTHER'S MAIDEN NAME <u>Julia Ruth</u>		
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>					17. SOCIAL SECURITY NO. <u>215-01-6417</u>		18. INFORMANT ADDRESS <u>Mrs. Catherine Prell 7201 Shadow Lawn Ave. 21234</u>		
19. <u>410-9</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial infarction, recent</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Arteriosclerotic cardiovascular disease</u>									
20A. DATE OF OPERATION <u>2</u>					20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			21. AUTOPSY? (Yes or No) <u>yes</u>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?		
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <u>Marvin S. Platt</u> M.D. EXAMINER'S NAME (Type) <u>Marvin S. Platt, M.D.</u> DATE SIGNED <u>9/23/72</u>									
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/26/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Gardens of Faith Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Overlea Balto. Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 26 1972</u>		25B. NAME OF REGISTRAR <u>Sidney</u>		25C. FUNERAL DIRECTOR <u>Lassahn Funeral Home</u>		ADDRESS <u>7401 Belair Rd. Balto. 21236</u>			

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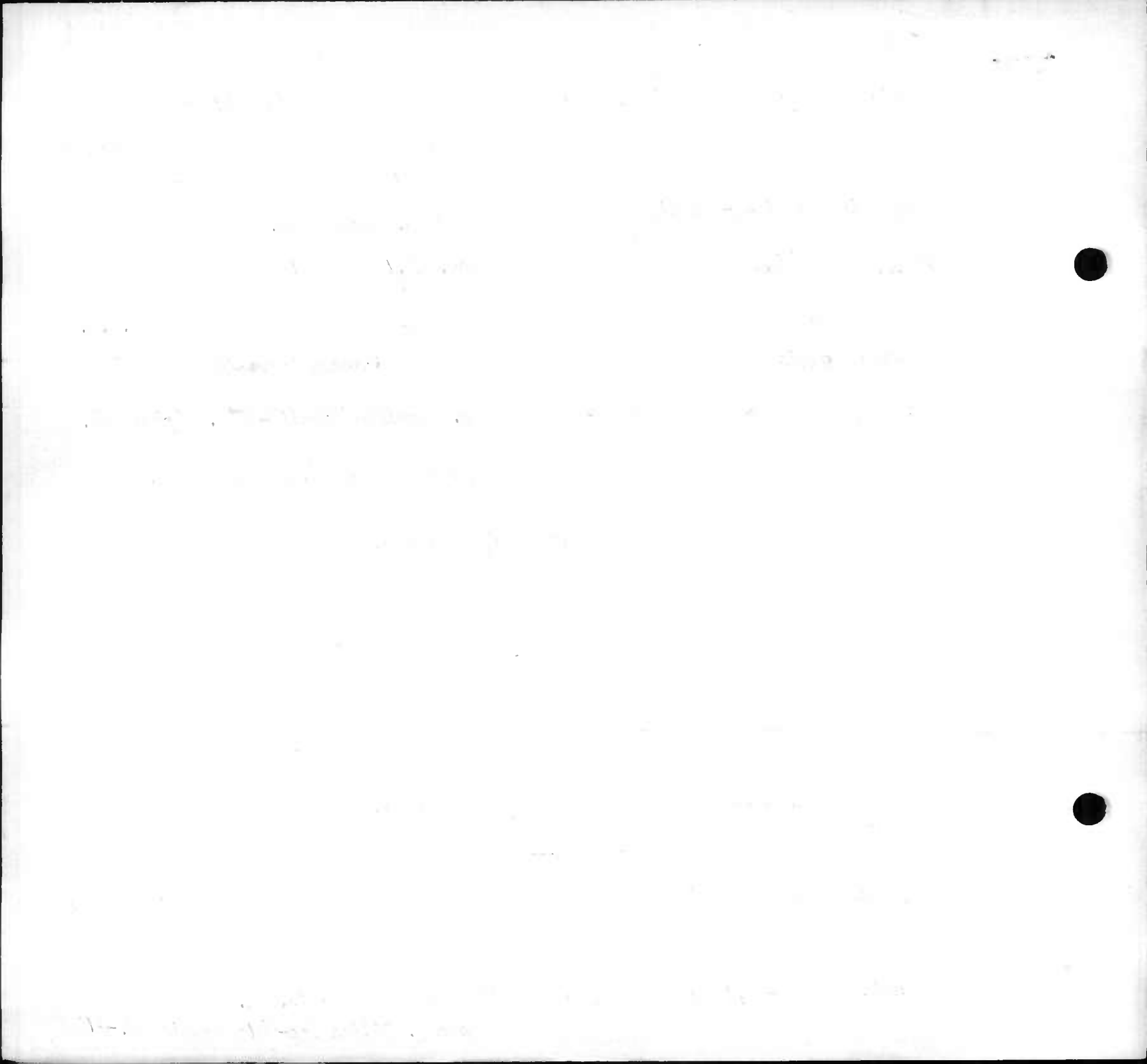
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

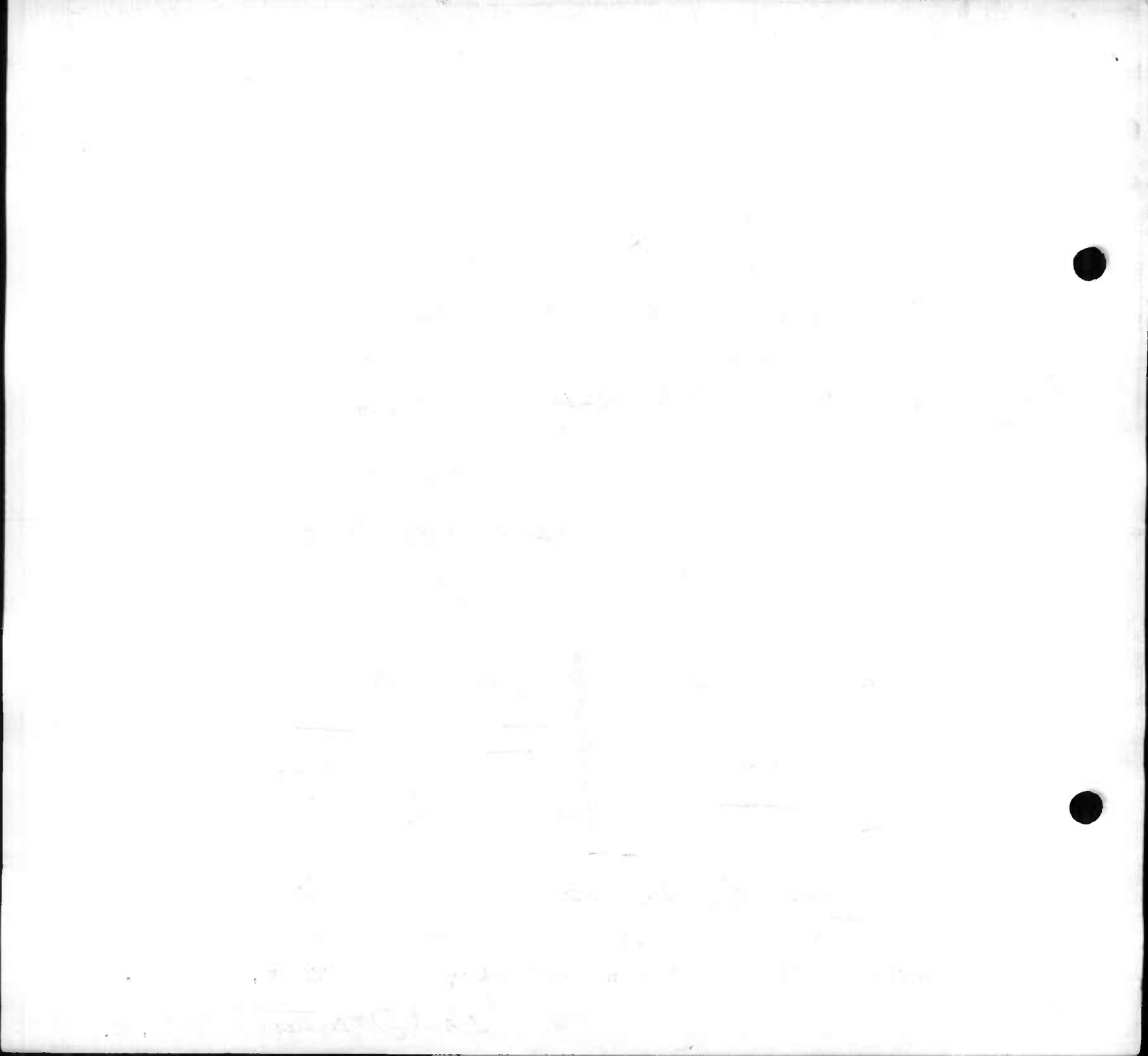
T-160		72 09184		BALTIMORE CITY HEALTH DEPARTMENT		72 09184	
BIRTH NO.		CERTIFICATE OF DEATH				REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH				STATE OF MARYLAND-DHMH	
Maria (MARY) TIBERI		9/22/72 9:55 A.M.				601	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE B. COUNTY		C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 70 House in the Pines-Belair		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		Maryland		Baltimore	
E. STREET AND NUMBER 28 N. Decker Ave.		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 27, 1890	
9. SEX Female		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Maker		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE in years last birthday 81	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph Boggio		14. MOTHER'S MAIDEN NAME Frances Prevosto	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Mr. Flaminio Tiberi - 28 N. Decker Ave.		ADDRESS	
18. 417-31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause. (All stating the UNDERLYING CONDITION last.)		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Artificially Heart Disease (B) Coronary Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF: (C) ...		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours years		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Recent Urinary Tract Infection Recent "Lith. Stones"	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indefinite medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 12/25/19 71 to 9/22/19 72 that (I) (we) last saw the deceased alive on 9/6/19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Albert B. Bradley	
23B. DATE SIGNED 9/22/72		23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		23E. FUNERAL DIRECTOR John C. Miller Inc-6415 Belair Rd.-21206	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-25-1972		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cemetery		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 26 1972		25B. NAME OF REGISTRAR		25C. ADDRESS		25D. ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
K-216		72 09185		72 09185	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		STATE OF MARYLAND - DHEH	
Chris Kaspary		10:05 / 9/23/72		A	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE B. COUNTY	
Vof Md. Hospital		Maryland		2533	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
38		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
M		Caucasian		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH		9. AGE (in years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
8-23-07		65		Shoe repair	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		10B. KIND OF BUSINESS OR INDUSTRY	
Pa.		USA		self-employed	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
George Kaspary		Barbara		UNKNOWN	
16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH	
216/224262		Chert		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH	
19. 162-1 I		(A) IMMEDIATE CAUSE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF:		Hypercalcemia -		2 wks.	
(B) DUE TO, OR AS A CONSEQUENCE OF:		Liver metastasis		3 mos	
(C) DUE TO, OR AS A CONSEQUENCE OF:		Bronchogenic Carcinoma		9/72 - 6 mos	
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0 5/30		Superior Vena Caval Syndrome		No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 5/19 1972 to 9/23 1972 that (I) (we) last saw the deceased alive on 9/23 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
Louis Kandl MD		9/23		Louis Kandl	
23D. ADDRESS		23E. FUNERAL DIRECTOR		23F. ADDRESS	
Vof Maryland Hospital		Louis J. Bratter		SINGLETON FUNERAL HOME	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		9/27/72		Loudon Park Cemetery	
24D. LOCATION (City, town, or county)		24E. LOCATION (State)		24F. LOCATION (City, town, or county)	
Baltimore, Md.					
25A. DATE RECEIVED BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. NAME OF REGISTRAR	
SEP 26 1972		Randy Johnson		Louis J. Bratter	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09186		72 09186	
CERTIFICATE OF DEATH				REG. NO.		STATE OF MARYLAND - DEPT. HEALTH	
BIRTH NO. <b>S-164</b>		1. NAME OF DECEASED (Type or Print) <b>SPEERLING, FLORENCE ELLEN</b>		2. DATE AND HOUR OF DEATH <b>21 SEPT. 1972 8:30 p</b>		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>GATON MANOR NURSING HOME</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>AA</b>		5. CITY OR TOWN <b>Linthicum</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>CATON MANOR NURSING HOME</b>				7. STREET AND NUMBER <b>501 Cleveland Road</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>31 March 1898</b>	9. AGE (In years last birthday) <b>74</b>	10. If Under 1 Yr. Months: Days: Hours: Min.	11. If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>CHARLES WOLF</b>				14. MOTHER'S MAIDEN NAME <b>FLORENCE BENNETT</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>CHARLES A. PRICE, SON, SAME AS 4</b>		ADDRESS	
18. <b>440.9 I 4250.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cardio-respiratory failure</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Dehydration + Malnutrition</b> (C) <b>Arteriosclerosis + senility</b>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Diabetes Mellitus</b>							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>June 1972</b> to <b>21 Sept 1972</b> that (I) (we) last saw the deceased alive on <b>21 Sept 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>William J. Bryson M.D.</b>				23B. DATE SIGNED <b>22 SEPT. 72</b>			
23C. PHYSICIAN'S NAME (Type) <b>WILLIAM J. BRYSON, M.D.</b>				23D. ADDRESS <b>5772 WESTVIEW MALL, BALTIMORE</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>25 SEPT. 72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>WOODLAWN CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, BALTO., MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1972</b>		25B. NAME OF REGISTRAR <b>Asbury</b>		25C. FUNERAL DIRECTOR <b>KIRKLEY FUNERAL HOME, GLEN BURNIE, MD.</b>		ADDRESS	

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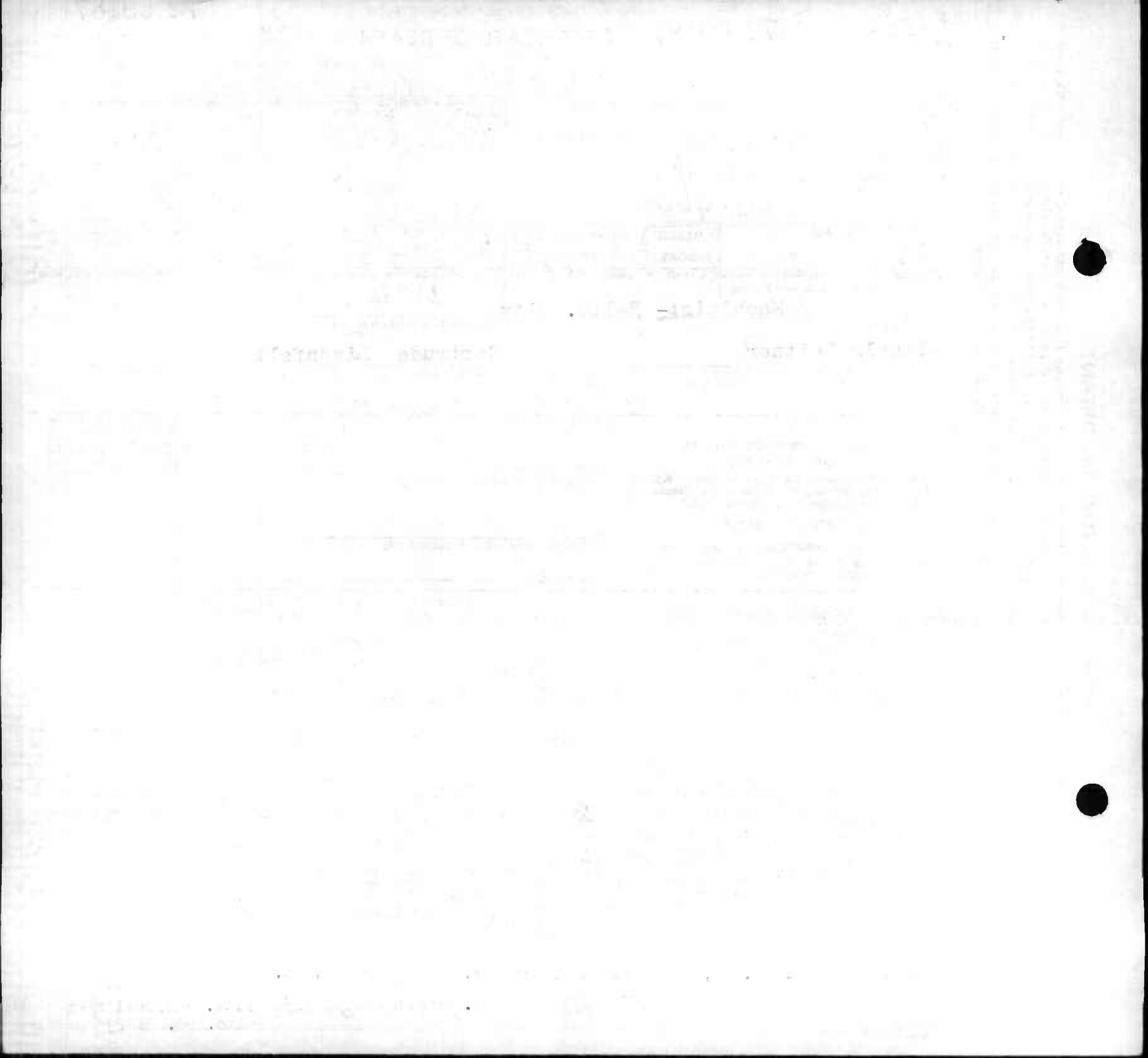
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1-356		72 09187		BALTIMORE CITY HEALTH DEPARTMENT		72 09187	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) FRANK A. LEITNER				2. DATE AND HOUR OF DEATH 9-22-72 2:45 PM 2:45 M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MARYLAND GEN. HOSP BALTO, Maryland				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND, B. COUNTY BALTO. C. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 7001 Dogwood Road			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-04-05	9. AGE (In years last birthday) 66	10. UNDER 1 Yr. Months	11. UNDER 24 Hrs. Days	12. CITIZEN OF WHAT COUNTRY? U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machinist- Balto. City				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME Wilhelm Leitner				14. MOTHER'S MAIDEN NAME Gertrude Lisenfelt			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 217-26-7373		17. INFORMANT Medical Record ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH GENERALIZED LYMPHOSARCOMA ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Cellulitis @ Buttock & Gangrene				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 08-21-72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Excision of Gangrene Rotation Flap		20A. AUTOPSY (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the hospital) attended the deceased from 8-20-72 to 9-22-72 that (I) (we) last saw the deceased alive on 9-22-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE CLEMENT C. UGORSKI						23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) CLEMENT C. UGORSKI						23D. ADDRESS Maryland Gen Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Sept. 25, 1972		24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cem.		24D. LOCATION (City, town, or county) Balto. Md. (State)	
25A. DATE REC'D BY HEALTH DEPT. SEP 26 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR G. Truman Schwab		ADDRESS 5151 Balto. National Pike Balto. Md. 21229	

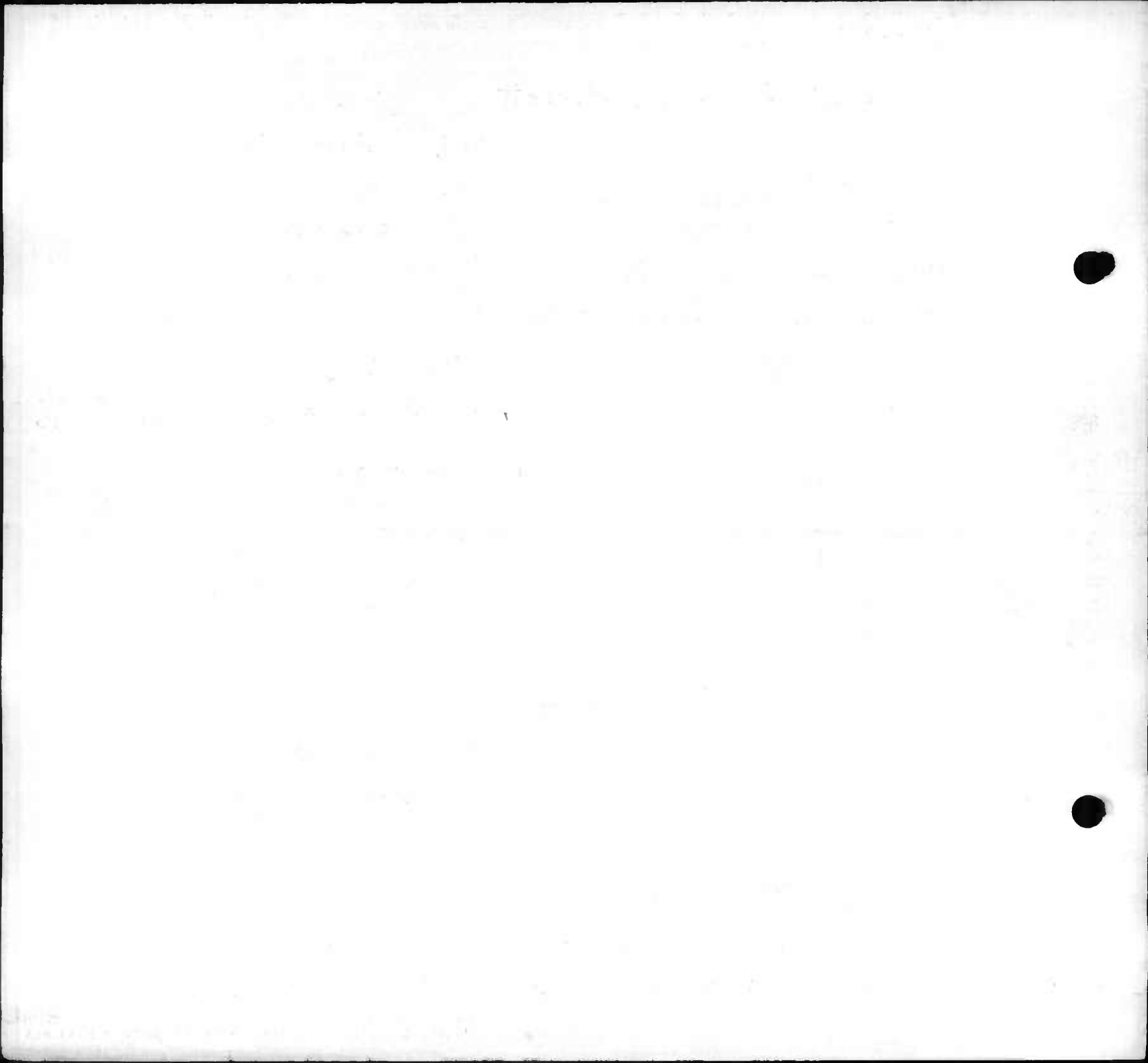




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-400		72 09188		BALTIMORE CITY HEALTH DEPARTMENT		72 09188	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Diehl, Clarence Everett</u>				2. DATE AND HOUR OF DEATH <u>9-22-72</u> <u>5 pm</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>South Baltimore General Hospital</u> <u>3001 South Hanover Street</u> <u>Baltimore, Md. 21230</u>				A. STATE <u>Md.</u> B. COUNTY <u>Balto. Co.</u>			
				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>1331 Maple Ave.</u>			
5. SEX <u>Male</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-31-03</u>	9. AGE (In years last birthday) <u>69</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Contracting</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Diehl</u>				14. MOTHER'S MAIDEN NAME <u>Jane Trexler</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-09-366</u>		17. INFORMANT <u>Mrs. Rice</u>		ADDRESS <u>Bethlehem Pa.</u>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>Acute myocardial infarction (Baltimore)</u> <u>ASCD</u> <u>Chronic Med. Pulmonary arrest</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <u>9/10/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>9/18/72</u> to <u>9/22/72</u> that (I) (we) last saw the deceased alive on <u>9/22/72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>9/22/72</u>		23C. PHYSICIAN'S NAME (Type) <u>DR. CARLOS N. PATALINEAU</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/26/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Hellertown Union Cem</u>		24D. LOCATION (City, town, or county) (State) <u>Hellertown, Pa.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 26 1972</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>Wm. E. Johnson</u>		ADDRESS <u>8521 Loch Raven Blvd.</u>	



# FUNERAL DIRECTOR: IMPORTANT

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7-630		72 09189		REG. NO. 72 09189	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>CICELIA FORD</b>		2. DATE AND HOUR OF DEATH <b>September 21, 1972 8:15 PM.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2841</b>		C. CITY OR TOWN <b>BALTIMORE</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>90 CATON MANOR NURSING CENTER</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>F</b>		6. RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waitress</b>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <b>9-10-1905</b>	
13. FATHER'S NAME <b>George Fiedler</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		9. AGE (In years last birthday) <b>67</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Yes</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
17. INFORMANT <b>George Ford - Same</b>		ADDRESS		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
18. <b>1579 I</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Tumoral cachexia</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Disseminated metastasis</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Adenocarcinoma pancreas</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Adenocarcinoma pancreas</b>			
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>April 3-72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Spinal Cord Myeloma</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>May 1</b> 19 <b>72</b> to <b>Sept 21</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>9-15</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Alexander L. Ford</b>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>ALEXANDER L. FORD</b>				23D. ADDRESS <b>Staple Line, Inc.</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>9-25-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1972</b>		25B. NAME OF REGISTRAR <b>Sidney [Signature]</b>	
25C. FUNERAL DIRECTOR <b>ARMACOST FUNERAL HOME</b>		ADDRESS <b>CHapel 4600 Liberty Heights Ave.</b>			

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# FUNERAL DIRECTOR: IMPORTANT

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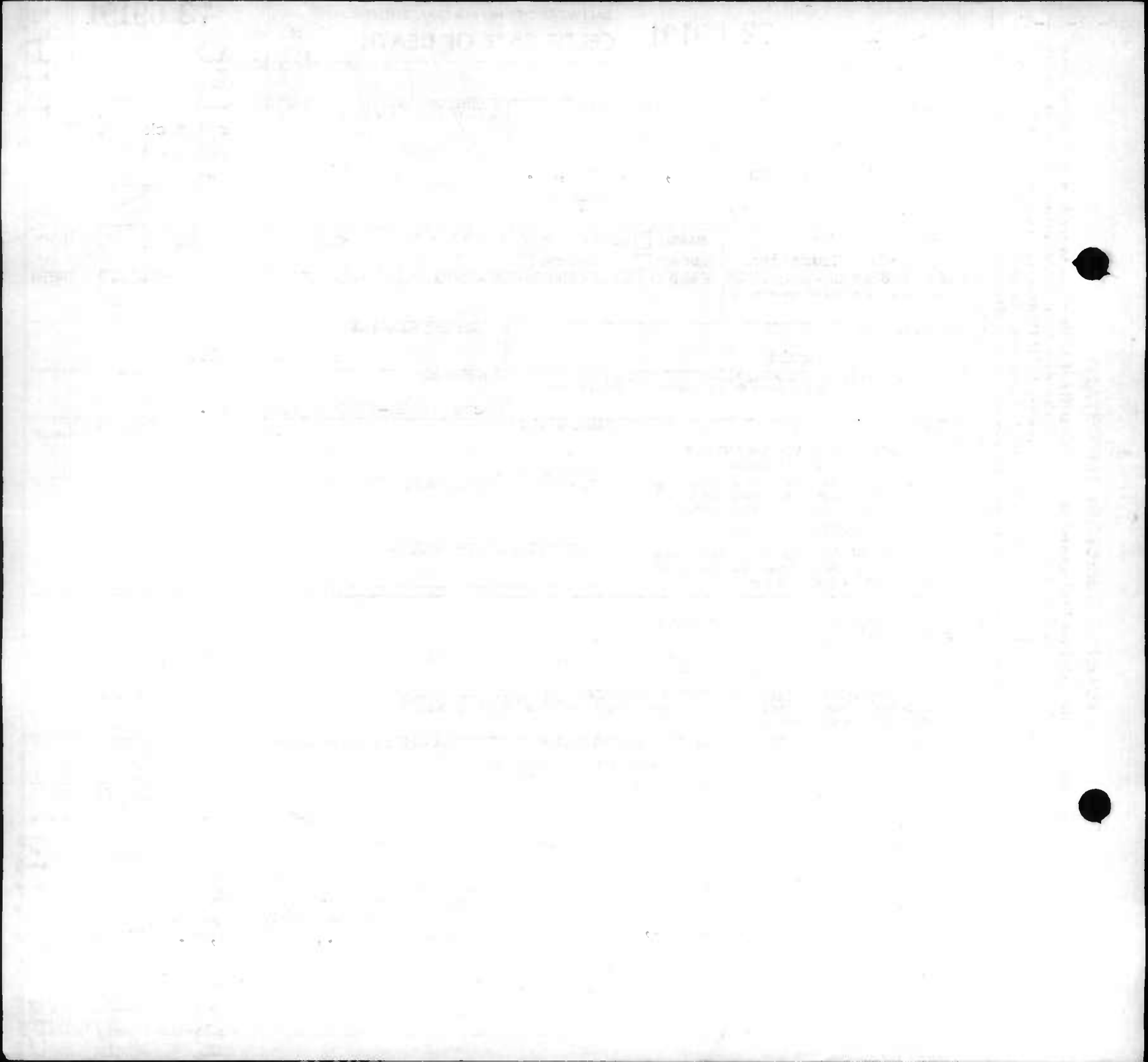
BALTIMORE CITY HEALTH DEPARTMENT				72 09190		72 09190	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
LOWERY JAMES				Sep. 22 - 72 4:05 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
South Baltimore Gen. Hosp.				Md. Balto. 2302			
5. SEX M 6. RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				C. CITY OR TOWN D. INSIDE CITY LIMITS?			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				E. STREET AND NUMBER			
Unknown				1015 Belking Rd.			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
Md.				U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Charles. (see).				Pearl (see).			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
No				212-12-6204			
17. INFORMANT				ADDRESS			
Louise Lowery				1617 Elkins Lane			
18. CAUSE OF DEATH							
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH							
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)							
ANTECEDENT CAUSES							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: suspected, M.I. with Car.ogenic shock.							
(B) DUE TO, OR AS A CONSEQUENCE OF: ASVD.							
(C) Generalized arteriosclerosis.							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sep. 19 1972 to Sep. 22 1972, that (I) (we) lost saw the deceased alive on Sep. 22 1972, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
F. Rios M.D.				Sep. 22 - 72.		FELIPE RIOS	
23D. ADDRESS				23E. DATE REC'D BY HEALTH DEPT.			
South Balto. Gen. Hosp.				SEP 26 1972			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial				9-22-72		Radar Hill Cemt.	
24D. LOCATION (City, town, or county) (State)				24E. NAME OF REGISTRAR			
Balto. Md.				Sidney H. Hester			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
SEP 26 1972				Sidney H. Hester		J. J. Gully	
25D. ADDRESS							
Funeral Home 130 E. Fort Ave. 21230							



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>D-142</b>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 69191</b>	
1. NAME OF DECEASED (Type or Print) <b>Margaret Devilbiss</b>		2. DATE AND HOUR OF DEATH <b>9/22/72 4<sup>55</sup> A M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived; if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Frederick</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>4940 Eastern Avenue, Baltimore, Md. Baltimore City Hospitals 21224</b>		C. CITY OR TOWN <b>Walkersville</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>Female</b>		6. RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>7/4/93</b>		9. AGE (In years last birthday) <b>79</b>		10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>David</b>			
14. MOTHER'S MAIDEN NAME <b>Ida Belle</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Records: BCH-4940 Eastern Ave. 21224</b>			
18. <b>205.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Acute Myelomonocytic Leukemia</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Acute Renal Failure</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>8/8</b> 19 <b>72</b> to <b>9/22</b> 19 <b>72</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>9/22</b> 19 <b>72</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (did) (did not) view the body after death.					
23A. SIGNATURE <b>Roland C. Einhorn, MD</b>		23B. DATE SIGNED <b>9/22/72</b>		23C. PHYSICIAN'S NAME (Type) <b>Roland C Einhorn, MD</b>	
23D. ADDRESS <b>Baltimore City Hospitals, 4940 Eastern Ave., Baltimore, Md. 21224</b>					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>9-23-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>U of M. Anatomy Bldg</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore MD</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1972</b>		25B. NAME OF REGISTRAR <b>Raymond J. Curran</b>		25C. FUNERAL DIRECTOR <b>817 SEARLETT DR. TOWSON, MD 21204</b>	





72 09192

STATE OF MARYLAND-DEMH  
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 09192

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) CHARLES L. BAUBLITZ		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> September 21, 1972		M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4137 Hyden Court 10-12-72		3. DATE PRONOUNCED DEAD Month Day Year Hour September 21, 1972 12:01 A.		M.
6. SEX Male		7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. DATE OF BIRTH UNKNOWN		10. AGE (In years lost birthday) 57		11. BIRTHPLACE (State or foreign country) UNKNOWN
12. CITIZEN OF WHAT COUNTRY? UNKNOWN		13. FATHER'S NAME UNKNOWN		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN
15. MOTHER'S MAIDEN NAME UNKNOWN		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (if yes, give war or dates of service) UNKNOWN		17. SOCIAL SECURITY NO. UNK
18. INFORMANT BALT CITY MED EXAMINER		ADDRESS BALT CITY MED EXAMINER		
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Pulmonary hemorrhage Pulmonary emboli ANTecedent CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Chronic obstructive pulmonary disease Chronic pulmonary disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
20A. DATE OF OPERATION 22		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Marvin S. Platt, M.D. EXAMINER'S NAME (Type): Marvin S. Platt, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: September 21, 1972				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 9-25-72		24C. NAME OF CEMETERY OR CREMATORY NORMAN ANATOMY BOARD
24D. LOCATION (City, town, or county) (State) BALT MD		24E. FUNERAL DIRECTOR R.V. CURRAN		24F. ADDRESS 817 Seale Dr TOWSON, MD 21204
25A. DATE REC'D BY HEALTH DEPT SEP 26 1972		25B. NAME OF REGISTRAR [Signature]		25C. ADDRESS [Signature]

10-12-1972 - Letter from the Office of the Chief Medical Examiner-  
Marvin S. Platt, M.D., Assistant Medical Examiner HRS

1

72 09193 STATE OF MARYLAND - DEMH  
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 09193

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

BARBARA STOUGHTON

2. DATE  
OF DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

35 Church Home &amp; Hospital

3. DATE PRONOUNCED DEAD

Month

Day

Year

Hour

M.

8

27

1972

2:30a

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Md.

B. COUNTY

103

6. SEX

female

7. RACE

white

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

UNKNOWN

10. AGE (In years lost birthday)

48

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

2545 Eastern Ave.

11. BIRTHPLACE (State or foreign country)

UNKNOWN

12. CITIZEN OF

UNKNOWN

13. FATHER'S NAME

UNKNOWN

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

UNKNOWN

14B. KIND OF BUSINESS OR INDUSTRY

UNKNOWN

15. MOTHER'S MAIDEN NAME

UNKNOWN

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

UNKNOWN

17. SOCIAL SECURITY NO.

UNKNOWN

18. INFORMANT

ADDRESS

BALTIMORE MED EXAMINERS OFFICE

19.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

CAUSE OF DEATH

peritonitis secondary to ruptured duodenum

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

blunt trauma to abdomen

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

Bronchopneumonia

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)  
yes22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  
home22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?  
2545 Eastern Ave. 10322D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  
8-16-72 4 p.m.22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

Subj. pushed by boyfriend and struck stomach on a chair.

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL SIGNATURE  
EXAMINER'S NAME (Type)

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒  
ASSISTANT MEDICAL EXAMINER ☐  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-28-72

24A. BURIAL (CREMATION, REMOVAL) (Specify)

24B. DATE

9-25-72

24C. NAME OF CEMETERY or CREMATORY

U of M. Anatomy Bldg

24D. LOCATION (City, town, or county)

BALTO, MD

(State)

25A. DATE REC'D BY HEALTH DEPT.

SEP 26 1972

25B. NAME OF REGISTRAR

Aldrich H. H. H.

25C. FUNERAL DIRECTOR

Raymond J. Curran

ADDRESS

817 SCARLETT DR  
TOWSON, MARYLAND

80120 SC

31100 ST

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-620		72 09194		BALTIMORE CITY HEALTH DEPARTMENT		72 09194	
BIRTH NO.		72 09194		CERTIFICATE OF DEATH		STATE OF MARYLAND - DEPT	
1. NAME OF DECEASED <b>(VICTORIA) VICTORIA M. PRICE (PRAIS)</b>				2. DATE AND HOUR OF DEATH <b>9/24/72 3:50 PM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>601</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>CHURCH HOME &amp; Hospital 1024 Broadway Baltimore MD 21231</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>143 N KENWOOD AVE 21224</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-10-94</b>	9. AGE (in years last birthday) <b>77</b>	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Home Maker</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MD</b>	
13. FATHER'S NAME <b>MICHAEL MARKIEWICZ</b>				14. MOTHER'S MAIDEN NAME <b>CATHERINE ? ROLEWICZ</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>212 07 7873</b>		17. INFORMANT ADDRESS <b>Sigmont Price 143 N KENWOOD AVE</b>	
18. <b>250.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(A) IMMEDIATE CAUSE <b>Coronary Respiratory arrest - 20 min</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>ASHD. Congestive failure</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Also was Diabetic Mellitus</b>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <b>NO</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) 1 Month) (Day) 1 Year) 1 Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>9/7/1972</b> to <b>9/24/1972</b> that (I) (we) last saw the deceased alive on <b>9/24/1972</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>L. PADMA RASU. M.D.</b>				23B. DATE SIGNED <b>9/1/72</b>			
23C. PHYSICIAN'S NAME (Type) <b>L. PADMA RASU. M.D.</b>				23D. ADDRESS <b>CHURCH HOME &amp; HOSP BALTIMORE, MD</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/27/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Holy Rosary Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1972</b>		25B. NAME OF REGISTRAR <b>Aditya K. Kothari</b>		25C. FUNERAL DIRECTOR ADDRESS <b>M.F. Sadowski &amp; Sons 1808 Eastern Ave</b>			

(21284) 178

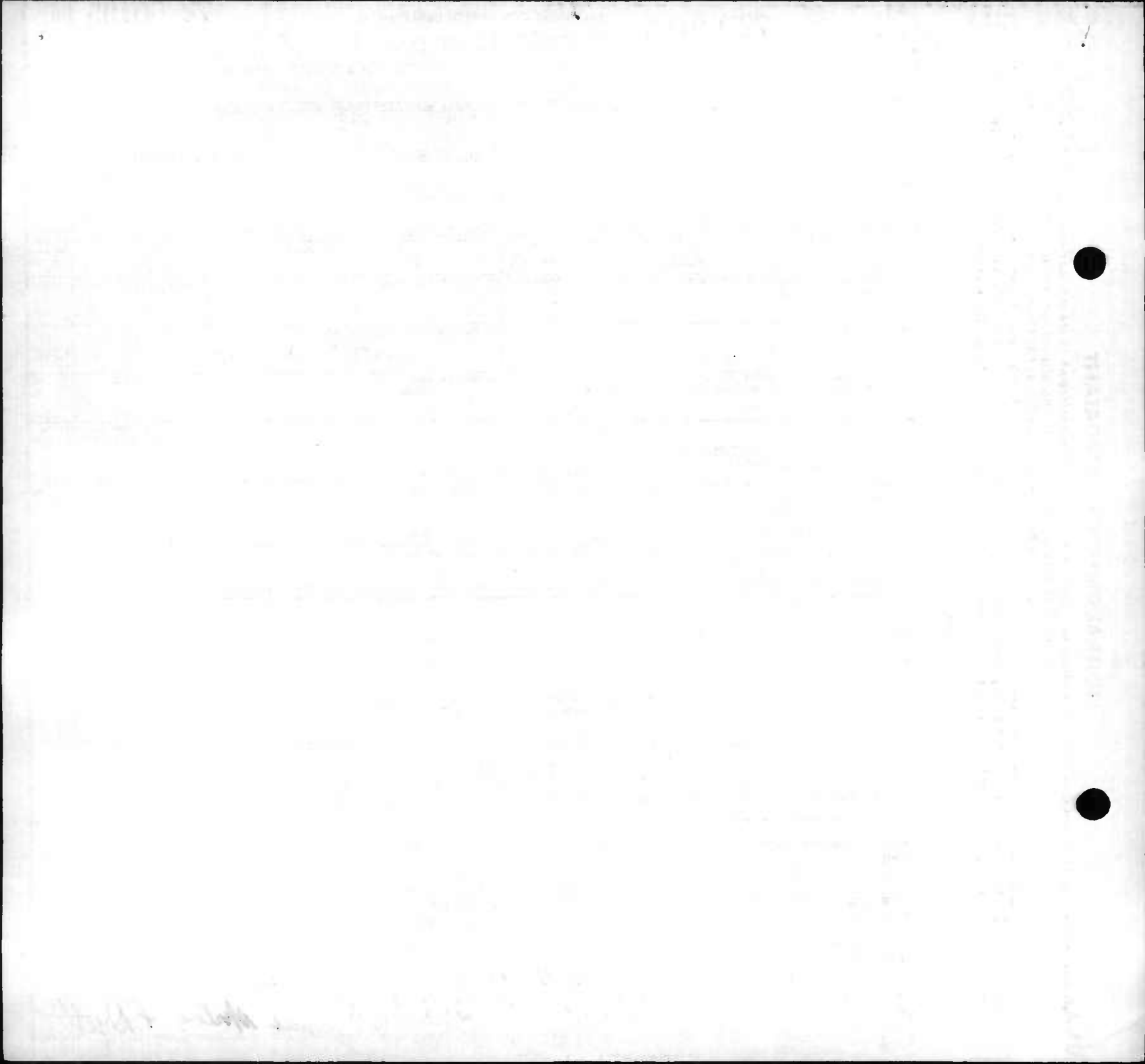
178

2017/3/16

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-200		72 09195		BALTIMORE CITY HEALTH DEPARTMENT		72 09195	
CERTIFICATE OF DEATH				REG. NO.			
1. NAME OF DECEASED (Type or Print) <u>LEWIS, WILLIAM H.</u>				2. DATE AND HOUR OF DEATH <u>Sept. 23<sup>rd</sup>, 1972</u> <u>8.20 AM.</u> <span style="float: right;">M.</span>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>PROVIDENT HOSPITAL, INC.</u> <u>2600, LIBERTY HEIGHTS, BALTO., MD, 21215.</u>				A. STATE <u>Maryland.</u>		B. COUNTY <u>1504</u>	
				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>2025, CLIFTON AVENUE</u>			
5. SEX <u>MALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 26<sup>th</sup>, 1915</u>		9. AGE (In years last birthday) <u>56 yrs.</u>	10. If Under 1 Yr. Months Days Hours Min. <u>11</u> <u>26</u> <u>8</u> <u>20</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONSTRUCTION WORK LABORER. CONSTRUCTION WORK.</u>			11. BIRTHPLACE (State or foreign country) <u>Virginia (LANCASTER CT.)</u>		12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES OF AMERICA.</u>		
13. FATHER'S NAME <u>LEWIS FAUNTLEROY J.</u>				14. MOTHER'S MAIDEN NAME <u>HATTIE JESSOP HATTIE E.</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>No.</u>		16. SOCIAL SECURITY NO. <u>139-18-3432</u>		17. INFORMANT ADDRESS <u>HOWARD LEWIS W. 148, 138 Street N.Y. N.Y. 10037</u>			
18. <u>191X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <u>CARDIO VASCULAR ACCIDENT</u> <u>8 days (approx)</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>MALIGNANCY OF BRAIN (as evidenced)</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>by Brain Scan studies.</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No.</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <u>Sept. 16<sup>th</sup>, 1972</u> <u>1972</u> to <u>Sept. 23<sup>rd</sup>, 1972</u> that (1) (we) last saw the deceased alive on <u>September 23<sup>rd</sup>, 1972</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Dilip K. Chhila</u> M.D. DEGREE				23B. DATE SIGNED <u>SEPT. 23<sup>rd</sup>, 1972.</u>		23C. PHYSICIAN'S NAME (Type) <u>DILIP K. USLA</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>				24B. DATE <u>9-27-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	
24D. LOCATION <u>BALTIMORE</u>				24E. CITY, TOWN, OR COUNTY <u>MARYLAND</u>		24F. STATE <u>MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 26 1972</u>				25B. NAME OF REGISTRAR <u>Andrew Johnson</u>		25C. FUNERAL DIRECTOR <u>James Morton &amp; Nyell</u>	

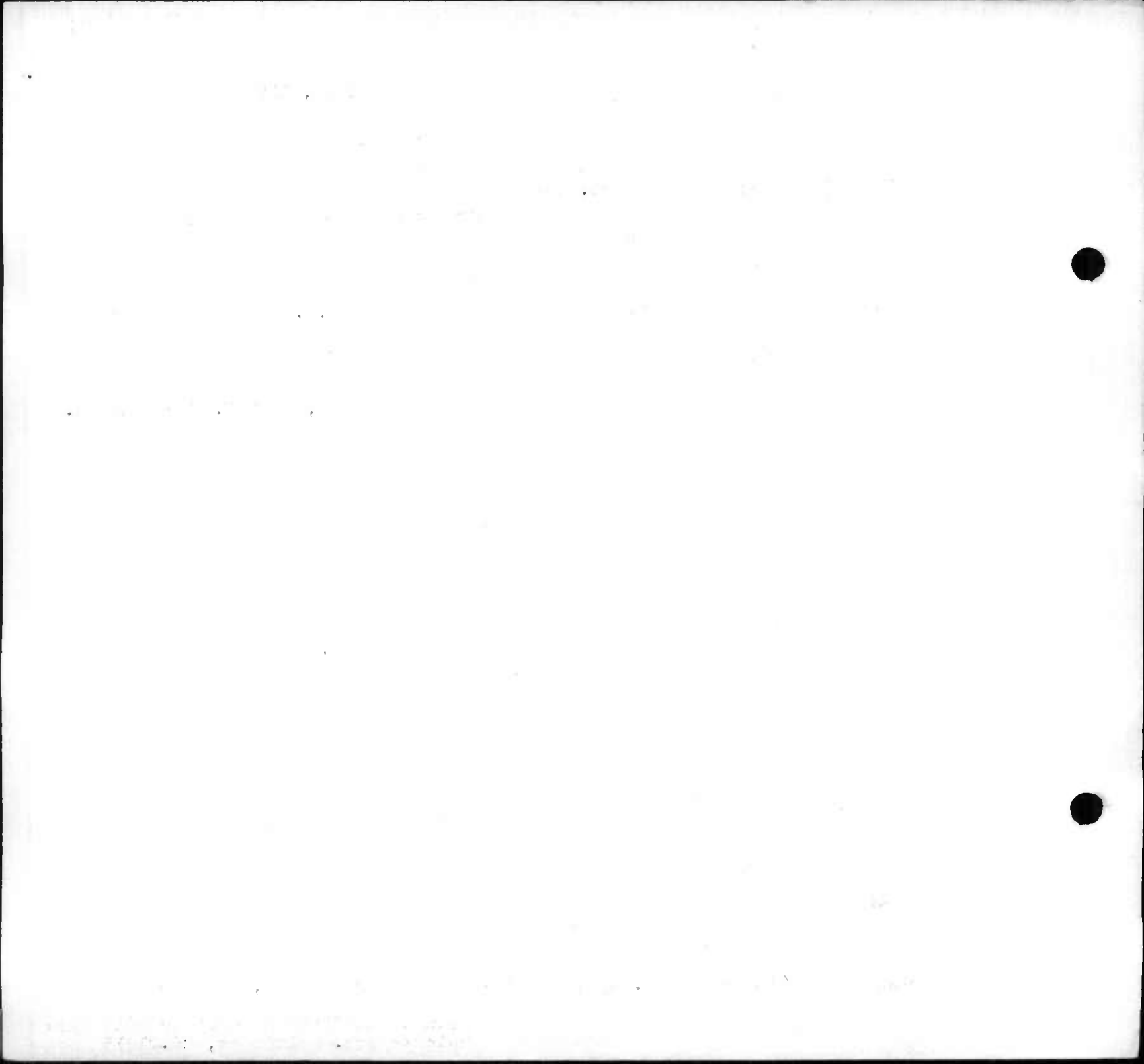






This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

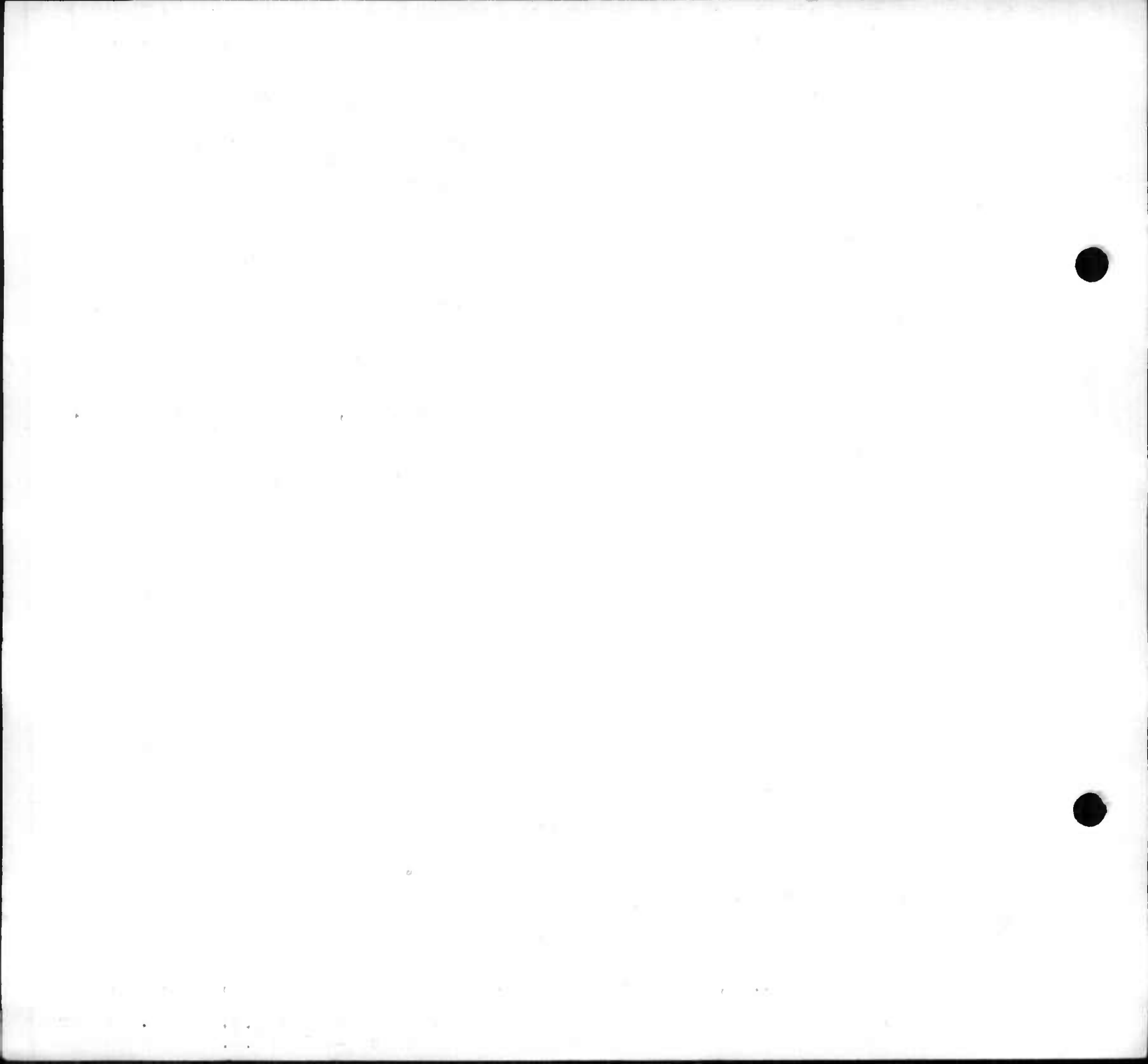
BIRTH NO. <span style="float: right;">72 09196</span>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <span style="float: right;">72 09196</span>	
1. NAME OF DECEASED (Type or Print) <b>CASSIE DAUGHTRY</b>			2. DATE AND HOUR OF DEATH <b>Sept 17, 1972</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>1710 North Caroline St. 21213</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>909</b>		
			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>1710 North Caroline Street</b>		
5. SEX <b>Male</b>	6. RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8.15.1904</b>	9. AGE (In years last birthday) <b>68 yrs.</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Laborer</b>		11. BIRTHPLACE (State or foreign country) <b>Rocky Mount N.C.</b>	
13. FATHER'S NAME <b>Will Daughtry</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>212101167</b>		17. INFORMANT <b>Ollie Daughtry, 1710 N. Caroline St.</b>
18. <b>582X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Systemic Hypertension, uncontrolled 2 ch Brain Syndrome 2 ch Renal Failure</b> (B) <b>2 ch Renal Failure</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White Al <input type="checkbox"/> Not White Al Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on <b>Sept 14, 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Firozi</b>			23B. DATE SIGNED <b>9/21/72</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <b>Firozi (Firozi) MD</b>			23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/22/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Calvary Cemetery</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		24E. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1972</b>			
24F. NAME OF REGISTRAR <b>James H. [illegible]</b>		25. FUNERAL DIRECTOR <b>Kenneth Law Funeral Chapels 4611 Park Heights Ave. Baltimore, Md. 21215</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

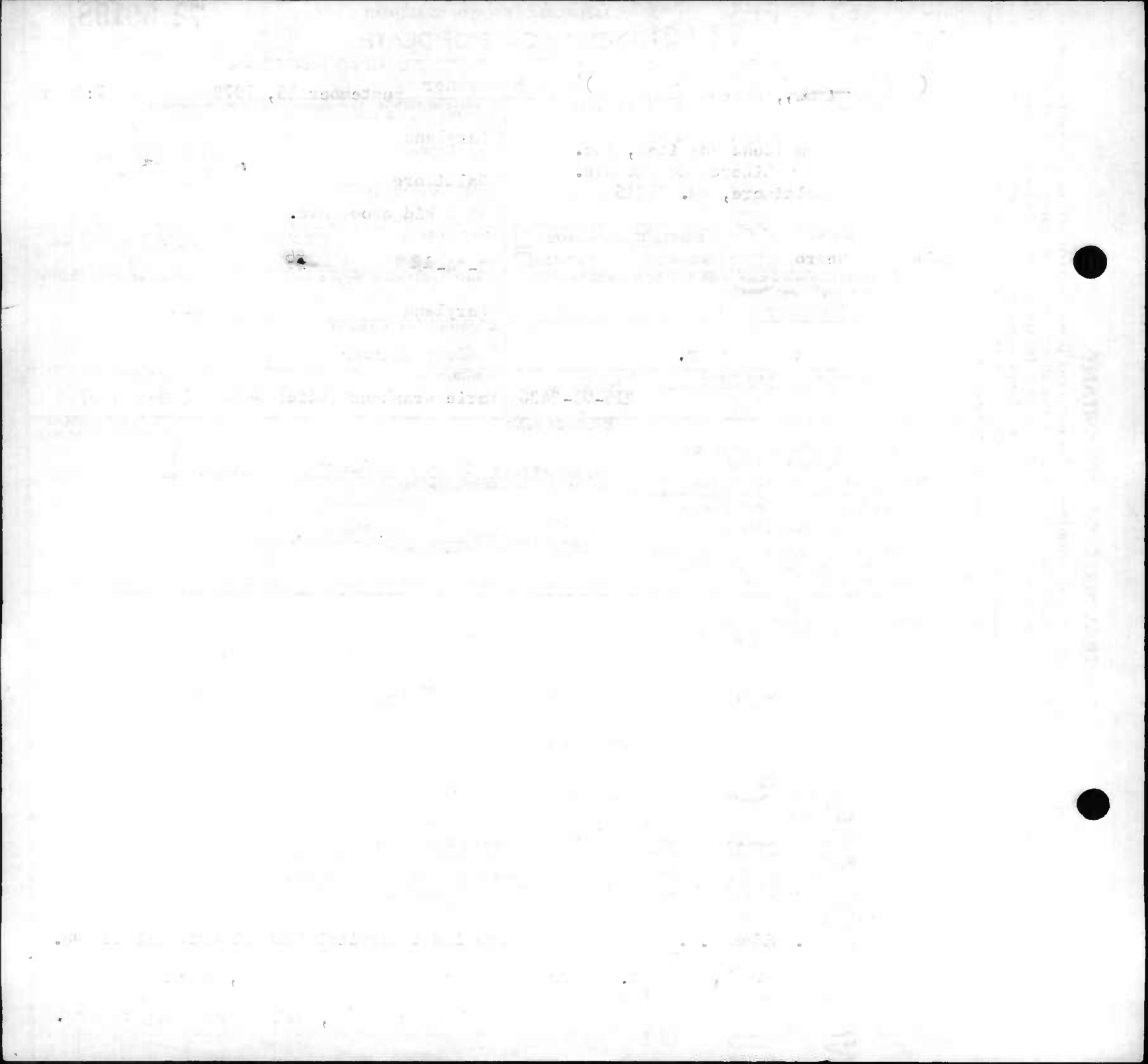
<p><b>G-120</b>      <b>72 09197</b>      <b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p style="font-size: 1.2em;"><b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. <b>72 09197</b></p> <p><b>STATE OF MARYLAND-DEATH</b></p>	
<p>BIRTH NO. _____</p> <p>1. NAME OF DECEASED (Type or Print) <b>JOHN TERRANCE GIBBS</b></p>		<p>2. DATE AND HOUR OF DEATH <b>9/16/72 8:30 PM</b></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNIV. of MD. HOSPITAL</b></p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</p> <p>A. STATE <b>MD.</b> B. COUNTY <b>BALTO CITY</b> C. CITY OR TOWN <b>1502</b></p> <p>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <b>1320 N. FULTON AVE</b></p>	
<p>5. SEX <b>M</b></p>	<p>6. RACE <b>BLK</b></p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <b>5-11-55</b></p>
<p>9. AGE (In years last birthday) <b>17</b></p>		<p>If Under 1 Yr. Months _____ Days _____</p>	<p>If Under 24 Hrs. Hours _____ Min. _____</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STUDENT</b></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY —</p>	
<p>11. BIRTHPLACE (State or foreign country) <b>NEWARK, NEW JERSEY</b></p>		<p>12. CITIZEN OF WHAT COUNTRY? <b>USA</b></p>	
<p>13. FATHER'S NAME <b>SAMUEL GIBBS</b></p>		<p>14. MOTHER'S MAIDEN NAME <b>MOZELLE JONES</b> AS ABOVE</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>      None</p>		<p>16. SOCIAL SECURITY NO. None</p>	
<p>17. INFORMANT <b>Mozelle Gibbs, 1320 North Fulton Ave.</b></p>		<p>ADDRESS</p>	
<p>18. <b>177.9 I</b> CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Rhabdomyosarcoma metastatic</b></p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF: _____</p> <p>(C) _____</p>	
<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 yr 1 mo</b></p>			
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION <b>2</b></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No) <b>YES</b></p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>			
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	
<p>21F. HOW DID INJURY OCCUR?</p>			
<p>22. I certify that (I) (this hospital) attended the deceased from <b>7-14</b> 19 <b>72</b> to <b>9-16</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>9-16</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <b>Miriam C. Turner MD</b></p>		<p>23B. DATE SIGNED <b>9/16/72</b></p>	
<p>23C. PHYSICIAN'S NAME (Type) <b>MIRIAM C. TURNER MD</b></p>		<p>23D. ADDRESS <b>UNIV. HOSPITAL BALTO MD</b></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b></p>		<p>24B. DATE <b>Sept. 23, 72</b></p>	
<p>24C. NAME of CEMETERY or CREMATORY <b>Evergreen Cemetery</b></p>		<p>24D. LOCATION (City, town, or county) (State) <b>Winston-Salem, North Carolina</b></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1972</b></p>		<p>25B. NAME OF REGISTRAR <b>Sidney Johnston</b></p>	
<p>25C. FUNERAL DIRECTOR <b>Howard &amp; Robinson F.H.</b></p>		<p>ADDRESS <b>709 N. Patterson Winston-Salem N.C.</b></p>	



FUNERAL DIRECTOR: IMPORTANT

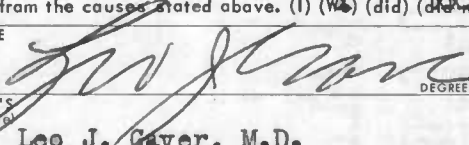

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

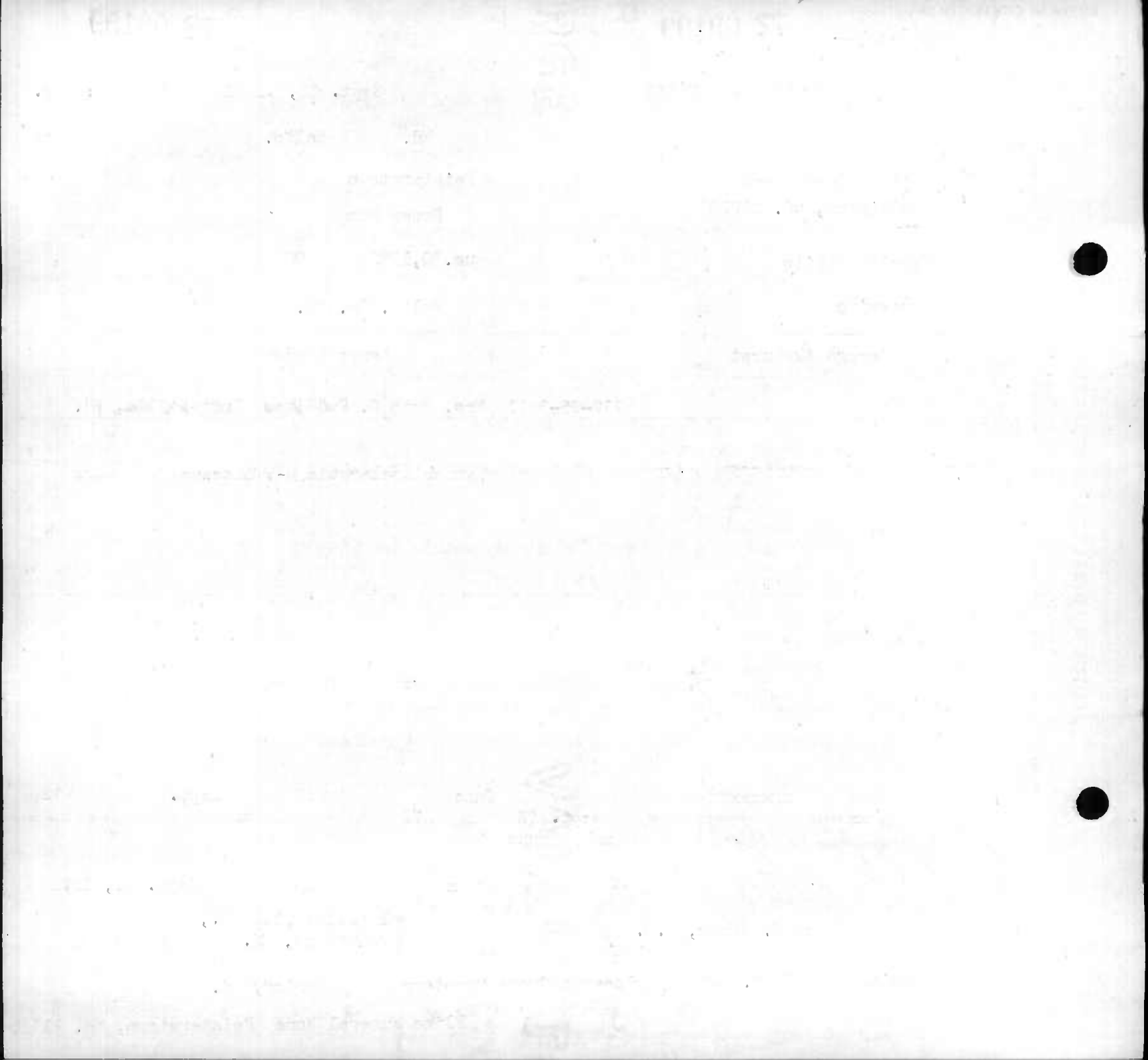
<p><b>R-256</b>      <b>72 09198</b>      <b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. <b>72 09198</b> <b>STATE OF MARYLAND-DIRECT</b></p>	
<p>BIRTH NO. <b>72 09198</b></p>		<p>1. NAME OF DECEASED (Type for Print) <b>(Ragher) (Raghner) Joseph Raghner</b></p>	
<p>2. DATE AND HOUR OF DEATH <b>September 15, 1972 7:00 p.m.</b></p>		<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>1510</b></p>	
<p>4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1510</b></p>		<p>5. FULL NAME OF HOSPITAL OR INSTITUTION <b>39</b> <b>Provident Hospital, Inc.</b> <b>2600 Liberty Height Ave.</b> <b>Baltimore, Md. 21215</b></p>	
<p>6. SEX <b>Male</b></p>		<p>7. RACE <b>Negro</b></p>	
<p>8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>9. AGE (In years last birthday) <b>59</b></p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>	
<p>11. BIRTHPLACE (State or foreign country) <b>Maryland</b></p>		<p>12. CITIZEN OF WHAT COUNTRY? <b>USA</b></p>	
<p>13. FATHER'S NAME <b>Joseph Raghner Sr.</b></p>		<p>14. MOTHER'S MAIDEN NAME <b>Jean Carter</b></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b></p>		<p>16. SOCIAL SECURITY NO. <b>219-01-2436</b></p>	
<p>17. INFORMANT <b>Marie Wraghner (Wife) SAME (Raghner)</b></p>		<p>ADDRESS</p>	
<p>18. <b>1957 I</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p><b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>Dehydration + Malnutrition</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Malignant Neoplasm of Neck</b> DUE TO, OR AS A CONSEQUENCE OF: (C)</p>	
<p>19. DATE OF OPERATION <b>2</b></p>		<p>20. AUTOPSY? (Yes or No) <b>YES</b></p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (1) (this hospital) attended the deceased from <b>9/15</b> <b>1972</b> to <b>9/15</b> <b>1972</b> that (1) (we) last saw the deceased alive on <b>9/15</b> <b>1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.</p>		<p>23A. SIGNATURE <b>Maurice R. Allen M.D.</b> DEGREE <b>Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/></b></p>	
<p>23B. DATE SIGNED <b>Sept. 15, 1972</b></p>		<p>23C. PHYSICIAN'S NAME (Type) <b>M. Allen M.D.</b> DEGREE <b>Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/></b></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b></p>		<p>24B. DATE <b>Sept 21, 72</b></p>	
<p>24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cemetery</b></p>		<p>24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1972</b></p>		<p>25B. NAME OF REGISTRAR <b>Kenneth Law</b></p>	
<p>25C. FUNERAL DIRECTOR <b>Kenneth Law</b></p>		<p>ADDRESS <b>4611 Park Heights Ave.</b></p>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 09199</b>	
G-652 72 09199				STATE OF MARYLAND-DHMH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Beulah L. Grimes		Sept. 23, 1972 8:05 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
Silver Cross Home Baltimore, Md. 21229			Md. Balto. 5300		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Reisterstown		YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			Dover Road		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Aug. 30, 1882	90	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Balto. Co. Md.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
George Akehurst			Laura Landon		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		212-05-3311		Mrs. Ruth G. Cullison Lutherville, Md.	
18. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			Arteriosclerotic C-V Disease years		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <del>this doctor</del> attended the deceased from June 19 68 to Sept. 19 72, that (I) <del>was</del> last saw the deceased alive on Sept. 23 19 72 and that in (my) <del>and</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) <del>not</del> view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
				Sept. 24, 1972	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Leo J. Gaver, M.D.		1 Mallow Hill Rd., Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		Sept. 26, 72		Pleasant Grove Cemetery	
				Boring, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
SEP 28 1972				Eline Funeral Home Reisterstown, Md. 21136	





1

STATE OF MARYLAND DEPT. OF HEALTH  
BALTIMORE CITY HEALTH DEPARTMENT

72 09200  
72 09200

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

BIRTH NO. \_\_\_\_\_ REG. NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>James L. Mayhand</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>9 23 72</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>34 Bon Secours Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>9 23 72 6:43 a.</b> M.	
6. SEX <b>male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2002</b>	
9. DATE OF BIRTH <b>04/02/43</b>		10. AGE (In years last birthday) <b>29</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Reubin Mayhand</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>	
15. MOTHER'S MAIDEN NAME <b>Susie Braxton</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO. <b>219-40-4680</b>		18. INFORMANT <b>Susie B. Mayhand-2450 Druid Hill Ave</b>	
19. <b>3049</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Intravenous narcotism</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Min.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <b>Marvin S. Platt</b> M.D. EXAMINER'S NAME (Type): <b>Marvin S. Platt, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: <b>9/23/72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>09/28/72</b>	
24C. NAME of CEMETERY or CREMATORY <b>Mount Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1972</b>		25B. NAME OF REGISTRAR <b>Edgar L. Lynch</b>	
25C. FUNERAL DIRECTOR <b>Edgar L. Lynch-2463</b>		ADDRESS <b>Druid Hill Av.</b>	

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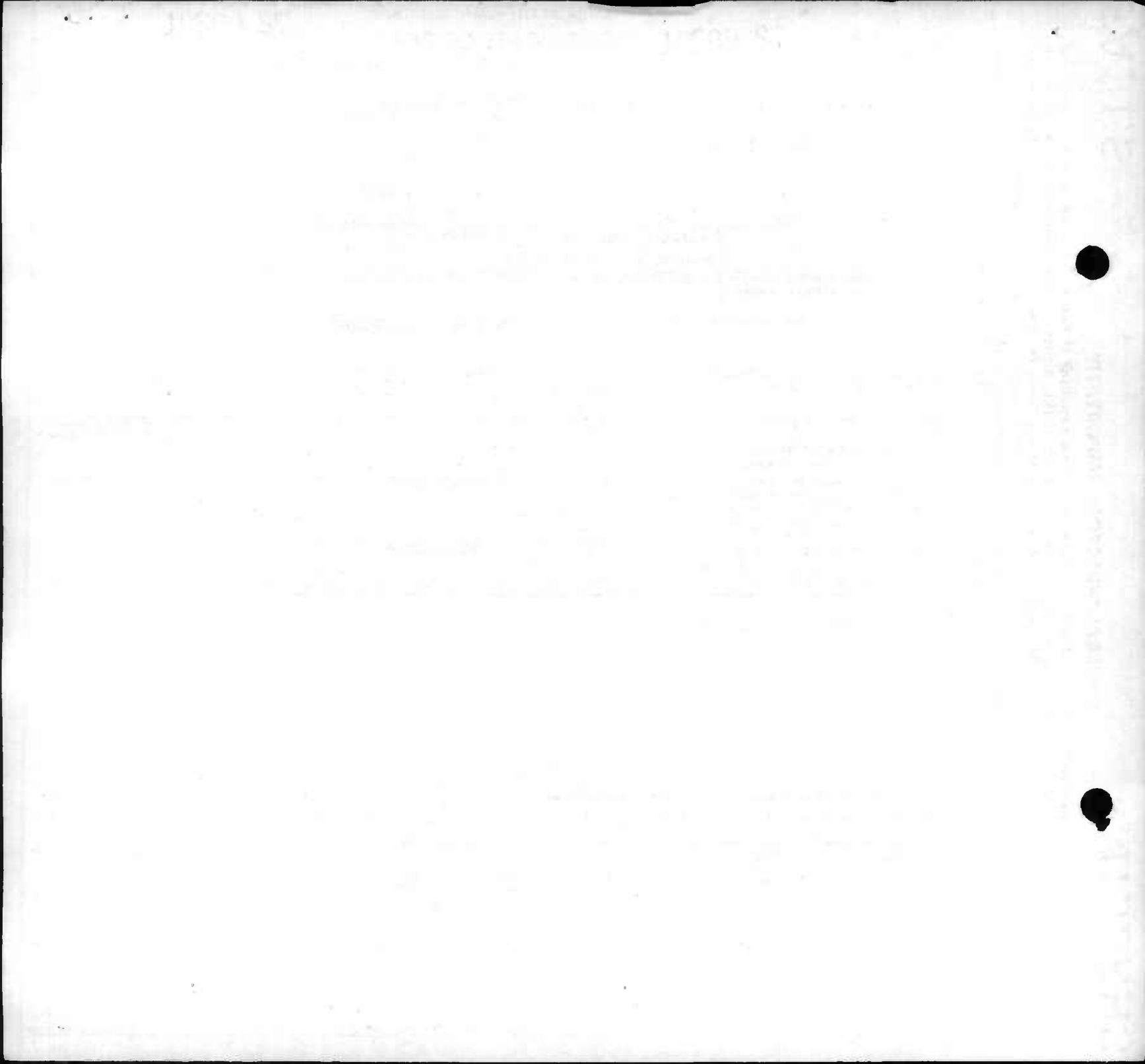
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 09201</b>	
BIRTH NO. <b>H 620 72 09201</b>				STATE OF MARYLAND - <b>DIMM</b>	
1. NAME OF DECEASED (Type or Print) <b>Harris, Pearl</b>			2. DATE AND HOUR OF DEATH <b>9/22/72</b> <b>9:15 P. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1301</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Provident Hospital</b> <b>2600 Liberty Heights</b> <b>Baltimore, Md. 21206</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>F</b> 6. RACE <b>B</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>3-4-97</b>		9. AGE (In years last birthday) <b>75</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>			11. BIRTHPLACE (State or foreign country) <b>Howard County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>214-14 9090</b>		17. INFORMANT <b>Mildred Brooks, daughter</b> <b>Mrs. Sonnie Curtis</b>
18. <b>15331</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Intestinal obstruction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>20 to Ca of Sigmoid Colon</b> <b>with metastasis</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 3 (A).					
19A. DATE OF OPERATION <b>8/17/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Intestinal obstruction</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8/16/72</b> to <b>9/22/72</b> and that (I) (we) last saw the deceased alive on <b>9/22/72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Bento Kong Leng COMD</b>				23B. DATE SIGNED <b>9/22/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>BENTO KONG-LENG COMD</b>				23D. ADDRESS <b>PROVIDENT Hospital Inc.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-26-72</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Zion Cem</b>	
24D. LOCATION <b>Baltimore, Md.</b>		25A. DATE RECEIVED BY HEALTH DEPT. <b>SEP 26 1972</b>			
25B. NAME OF REGISTRAR <b>Barney</b>		25C. FUNERAL DIRECTOR <b>Barney</b>			
25D. ADDRESS <b>1348 N. Carey</b>					



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STATE OF MARYLAND - DHEM BALTIMORE CITY HEALTH DEPARTMENT		72 09202	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 72 09202	
BIRTH NO.			
1. NAME OF DECEASED (Type or Print) <b>LAWRENCE KENT</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>September 21, 1972</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2432 Woodbrook Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>September 21, 1972 12:35 A.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1303</b>	
9. DATE OF BIRTH <b>7-18-12</b>		10. AGE (In years last birthday) <b>60</b>	
11. BIRTHPLACE (State or foreign country) <b>Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>decorator</b>		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
13. FATHER'S NAME <b>Wm. Kent</b>		15. MOTHER'S MAIDEN NAME <b>Addie Taylor</b>	
18. INFORMANT <b>Henry Kent - son</b>		ADDRESS <b>same</b>	
19. CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>Fatty metamorphosis of liver</b> DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Marvin S. Platt, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>September 21, 1972</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-25-72</b>	
24C. NAME of CEMETERY or CREMATORY <b>Arbutus Mem. Pk.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1972</b>		25B. NAME OF REGISTRAR <b>James H. Bailey</b>	
25C. FUNERAL DIRECTOR <b>Kelson &amp; H.</b>		ADDRESS <b>1348 Calhoun St.</b>	

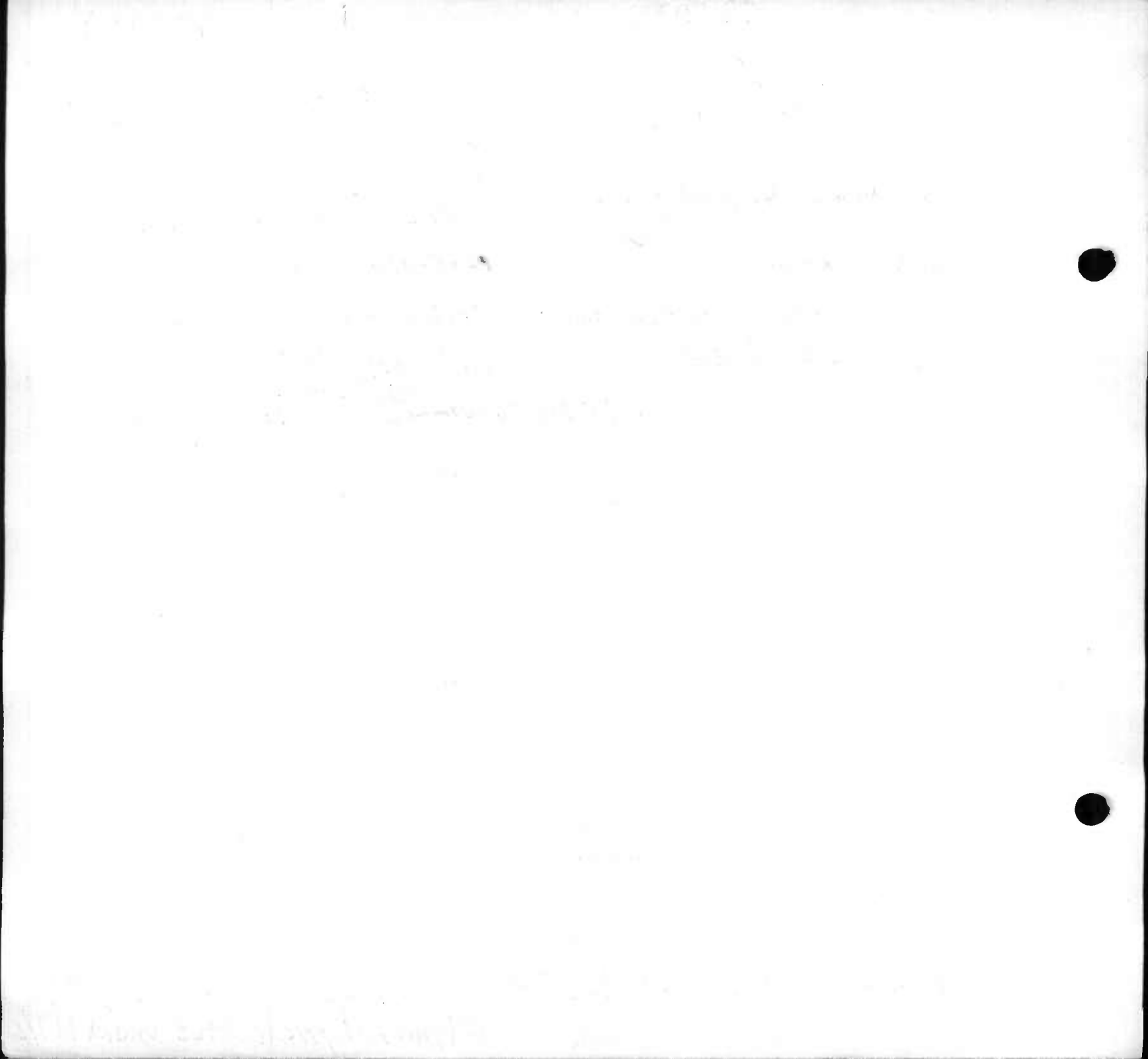
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 09203		BALTIMORE CITY HEALTH DEPARTMENT		72 09203	
L-000		NORBERT		STATE OF MARYLAND-DHMH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		John Lee		9/22/72 12 45/4. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE		
46 Lutheran Hospital of Md.			Md.		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			3512 Clifton Ave. 21216		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
male	Negro	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12-5-1911	60	11 Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
CHAUFFEUR		PRIVATE FAMILY		Baltimore Md	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
GEORGE LEE			Lillian Stiles		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		217-07-4790		ELEANOR G. LEE	
				ADDRESS	
				3512 Clifton Ave	
18. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			(A) IMMEDIATE CAUSE		
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			Gente Myocardial Infarction		
DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES			(B) DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) _____		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-20 1972 to 9-22 1972 that (I) (we) last saw the deceased alive on 9-22-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Lourdes M. Victoria M.D.				9-22-72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Lourdes M. Victoria M.D.				Lutheran Hosp. of Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		9/25/72		Arbutus Mem. Park. Arbutus (Baltimore, Md)	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
SEP 26 1972		S. Lynch		Edgar L. Lynch-2463 Druid Hill Ave	





P-632

72 09204 STATE OF MARYLAND-DEMH  
BALTIMORE CITY HEALTH DEPARTMENT

72 09204

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>RICHARD PRIDGEN</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> <b>September 22, 1972</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>3010 Baker Street</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>September 22, 1972 3:00 A.M.</b>	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1607</b>			
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>12-24-01</b>		10. AGE (In years last birthday) <b>70</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Dallas Bridgen</b>		14. MOTHER'S MAIDEN NAME <b>Sophia Westine</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>School System</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>215097223</b>	
17. INFORMANT <b>Mary Pridgen</b>		ADDRESS <b>same</b>	
19. <b>162.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Squamous cell carcinoma of lung</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>9-25-72</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>no</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Marvin S. Platt, M.D.</b> DATE SIGNED <b>9/22/72</b> EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-25-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Carver Mem. Pk.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1972</b>		25B. NAME OF REGISTRAR <b>Sidney [Signature]</b>	
25C. FUNERAL DIRECTOR <b>V. Bailey</b>		ADDRESS <b>1348 Calhoun Street</b>	

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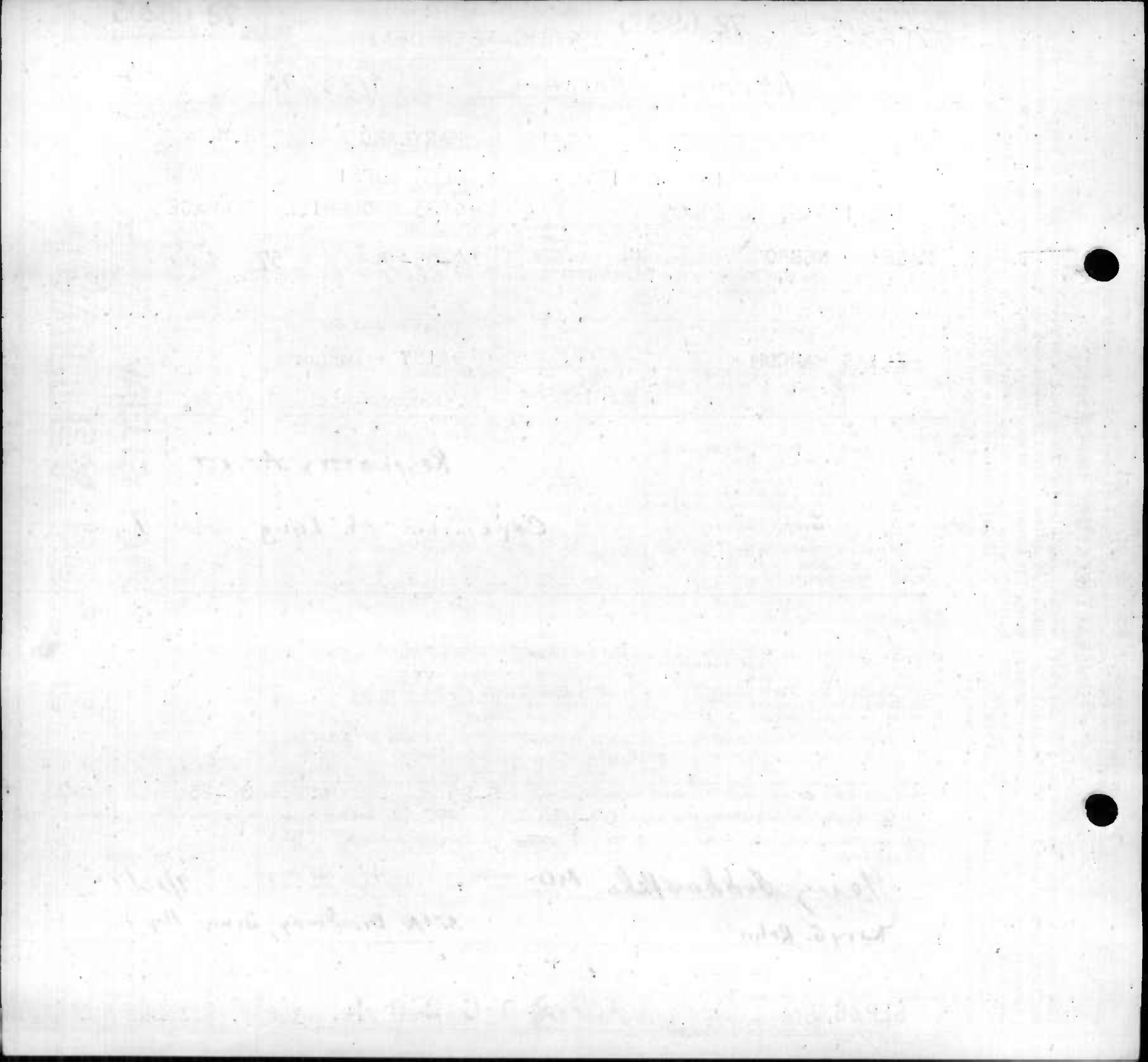
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

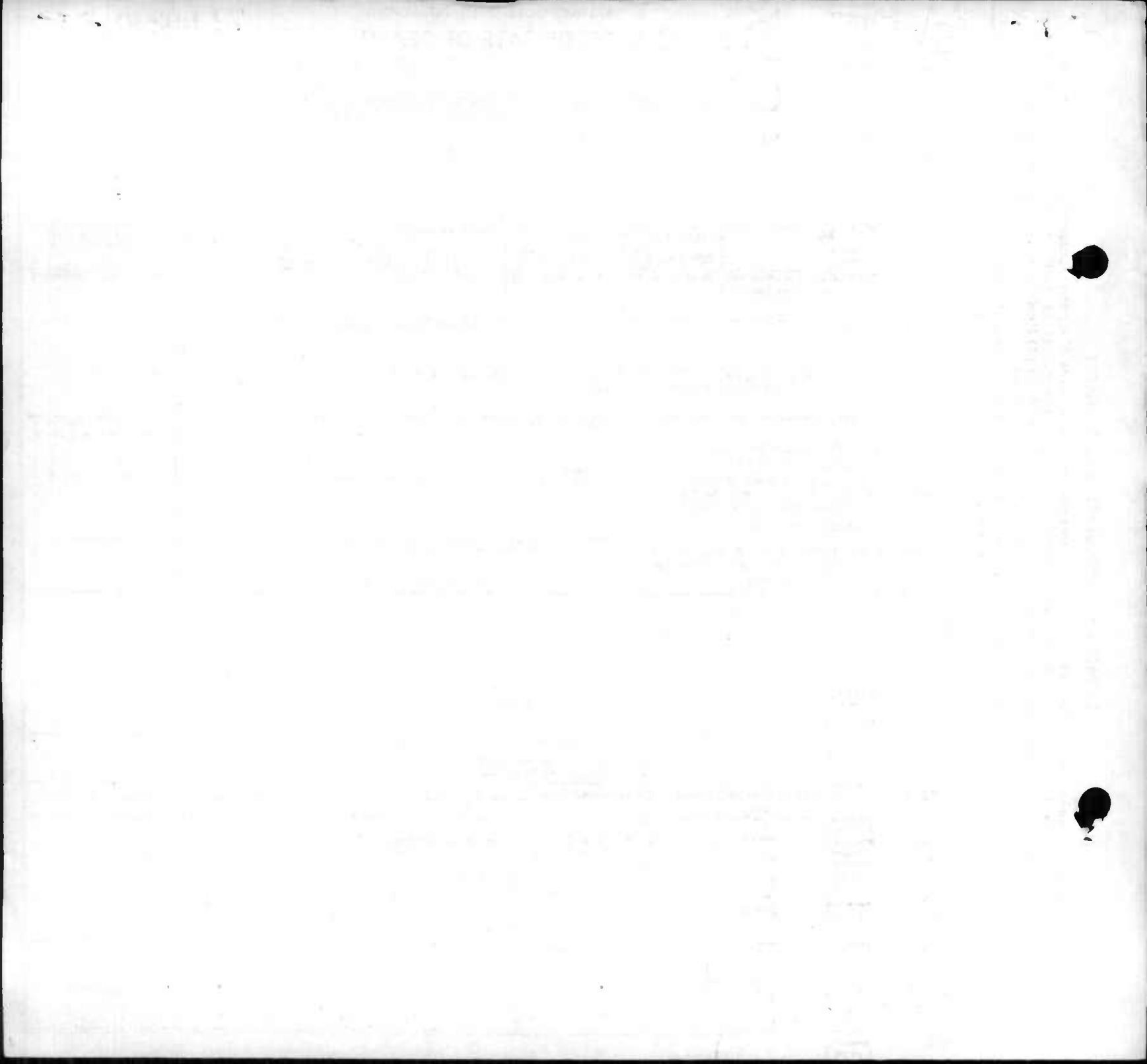
H-625		72 09205		BALTIMORE CITY HEALTH DEPARTMENT		72 09205	
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO.</span> <span>CERTIFICATE OF DEATH</span> <span>STATE OF MARYLAND - DEPT. OF HEALTH</span> </div>							
1. NAME OF DECEASED (Type or Print) <i>Norman Harcum</i>				2. DATE AND HOUR OF DEATH <i>9/23/72</i> <i>5</i> <i>A</i> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>A.A.</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>THE JOHNS HOPKINS HOSPITAL</i> <i>BALTIMORE, MD 21205</i>				C. CITY OR TOWN <i>GLEN BURNIE</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>MALE</i> 6. RACE <i>NEGRO</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <i>10-05-14</i>		9. AGE (In years last birthday) <i>57</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Longshoreman</i>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Va.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				13. FATHER'S NAME <i>ELIAS HARCUM</i>			
14. MOTHER'S MAIDEN NAME <i>DAISY Turner</i>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <i>229184605</i>				17. INFORMANT <i>L. Harcum-son</i>			
18. <i>1621 I</i> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <i>2</i> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <i>YES</i> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that <i>(1)</i> (this hospital) attended the deceased from <i>8-29</i> <i>1972</i> to <i>09-23</i> <i>1972</i> that <i>(we)</i> last saw the deceased alive on <i>09-23</i> <i>1972</i> and that in <i>(we)</i> (our) opinion death occurred on the date and hour and from the causes stated above. <i>(1)</i> (We) (did) ( <del>do not</del> ) view the body after death. 23A. SIGNATURE <i>Kerry G. Rehn MD</i> 23B. DATE SIGNED <i>9/23/72</i> 23C. PHYSICIAN'S NAME (Type) <i>Kerry G. Rehn</i> 23D. ADDRESS <i>500N Broadway, Johns Hop Kins Hospital</i> 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> 24B. DATE <i>9-27-72</i> 24C. NAME OF CEMETERY OR CREMAYORY <i>Church Cem.</i> 24D. LOCATION (City, town, or county) (State) <i>Northumberland Co., Va.</i> 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 26 1972</i> 25B. NAME OF REGISTAR <i>John H. Hooton</i> 25C. FUNERAL DIRECTOR <i>V. Bailey</i> ADDRESS <i>Kelson F.H. 1348 N. Calhoun St.</i>							



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

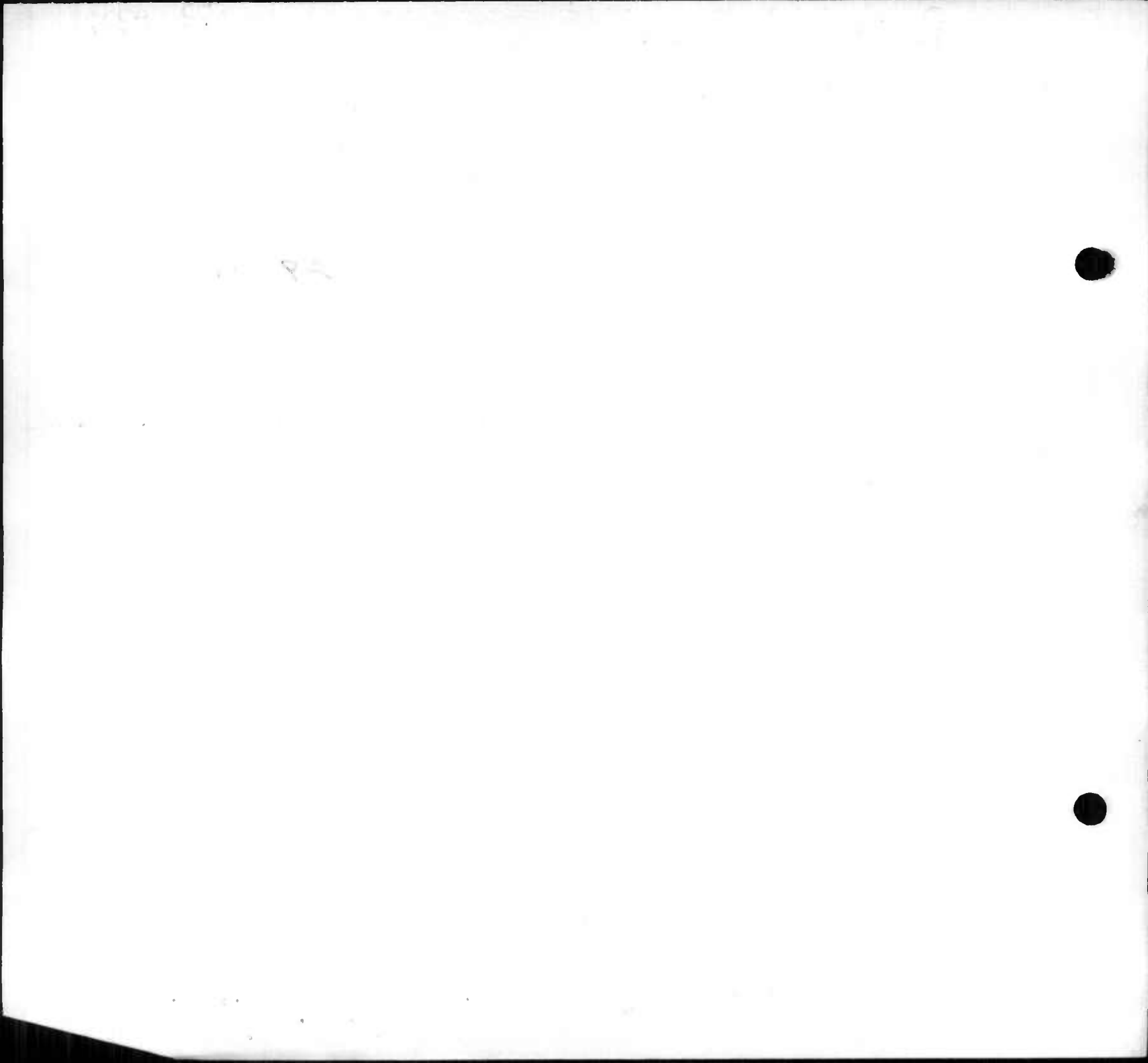
<div style="display: flex; justify-content: space-between;"> <span><b>J-525</b></span> <span><b>72 09206</b></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>		<b>REG. NO. 72 09206</b> STATE OF MARYLAND	
BIRTH NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type as Print) <b>VIVIAN JOANSON</b>		<b>SEPT. 23, 1972 3:25 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>MARYLAND GENERAL HOSP.</b> <b>827 LINDEN AVE.</b> <b>BALTIMORE, MD. 21201</b>		A. STATE <b>MARYLAND</b> B. COUNTY	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN <b>BALTIMORE</b>	
		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>1900 DRUID HILL</b>	
5. SEX <b>F</b>	6. RACE <b>B</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 9, 1936</b>
		9. AGE (In years last birthday) <b>46</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WAITRESS</b>		11. BIRTHPLACE (State or foreign country) <b>BALTO., MARYLAND</b>	
10B. KIND OF BUSINESS OR INDUSTRY <b>ROLLO RESTAURANT</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>CHARLES A. PLATO, SR.</b>		14. MOTHER'S MAIDEN NAME <b>VIOLA PLATO</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214-221138</b>	
		17. INFORMANT <b>ROBERT JOHNSON</b>	
		ADDRESS <b>BALTO., MD. 1900 DRUID HILL</b>	
18. <b>5-21-8 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Anoxia</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>about 12 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) <b>Nutritional Cirrhosis of liver</b> DUE TO, OR AS A CONSEQUENCE OF: <b>1 1/2 years</b>	
		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<b>Bronchopneumonia, bilateral</b> <b>10 days.</b>	
19A. DATE OF OPERATION <b>5</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>YES</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notably medical examined)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>SEPT. 11</b> 19 <b>72</b> to <b>SEPT. 23</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>SEPT. 23</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>[Signature]</b> MD DEGREE			23B. DATE SIGNED <b>9/23/72</b>
23C. PHYSICIAN'S NAME (Type) <b>RT MALLARI</b> MD DEGREE			23D. ADDRESS <b>BALTO., MD. 728 LINDEN AVE. 21201</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>9-27-72</b>	24C. NAME of CEMETERY or CREMATORY <b>Balto. Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1972</b>		25B. NAME OF REGISTRAR <b>[Signature]</b>	
		25C. FUNERAL DIRECTOR <b>W. Bailey</b> <b>Kelson F.H.</b> 1348 Calhoun Street	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p style="font-size: 24pt; margin: 0;">B-516</p> <p style="font-size: 24pt; margin: 0;">72 09207</p> <p style="margin: 0;">BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="font-size: 24pt; margin: 0;">72 09207</p> <p style="font-size: 24pt; margin: 0;">CERTIFICATE OF DEATH</p> <p style="margin: 0;">REG. NO. <span style="border: 1px solid black; padding: 2px;">72 09207</span></p>		<p style="margin: 0;">STATE OF MARYLAND-DEATH</p>	
<p>BIRTH NO. <span style="border: 1px solid black; padding: 2px;">B-516</span></p>		<p>1. NAME OF DECEASED (Type or Print) <span style="border: 1px solid black; padding: 2px;">Bumbray, Catherine</span></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION <span style="border: 1px solid black; padding: 2px;">University of Md. Hospital</span>  <span style="border: 1px solid black; padding: 2px;">38</span></p>		<p>2. DATE AND HOUR OF DEATH  <span style="border: 1px solid black; padding: 2px;">Sept 24, 1972</span> <span style="border: 1px solid black; padding: 2px;">11:42 A.</span> M.</p>	
<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)          A. STATE <span style="border: 1px solid black; padding: 2px;">Maryland</span>          B. COUNTY <span style="border: 1px solid black; padding: 2px;">2543</span></p>		<p>C. CITY OR TOWN <span style="border: 1px solid black; padding: 2px;">Baltimore</span>          D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p>E. STREET AND NUMBER <span style="border: 1px solid black; padding: 2px;">2408 Dorton Court</span></p>			
<p>5. SEX <span style="border: 1px solid black; padding: 2px;">F</span></p>	<p>6. RACE <span style="border: 1px solid black; padding: 2px;">N</span></p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>          WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <span style="border: 1px solid black; padding: 2px;">5-9-43</span></p>
<p>9. AGE (In years last birthday) <span style="border: 1px solid black; padding: 2px;">29 (29)</span></p>		<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  <span style="border: 1px solid black; padding: 2px;">Housewife</span></p>	<p>11. BIRTHPLACE (State or foreign country)  <span style="border: 1px solid black; padding: 2px;">Md.</span></p>
<p>12. CITIZEN OF WHAT COUNTRY?  <span style="border: 1px solid black; padding: 2px;">U.S.A.</span></p>			
<p>13. FATHER'S NAME  <span style="border: 1px solid black; padding: 2px;">Benjamin Coles (dec)</span></p>		<p>14. MOTHER'S MAIDEN NAME  <span style="border: 1px solid black; padding: 2px;">Louise Harris</span></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>		<p>16. SOCIAL SECURITY NO.</p>	<p>17. INFORMANT <span style="border: 1px solid black; padding: 2px;">Lonnie Coles</span>          ADDRESS <span style="border: 1px solid black; padding: 2px;">1605 Bruce St. Apt. 2</span></p>
<p>18. <span style="border: 1px solid black; padding: 2px;">207.01</span> CAUSE OF DEATH</p> <p style="text-align: center;">DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p style="text-align: center;">ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION <span style="border: 1px solid black; padding: 2px;">0</span></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No)  <span style="border: 1px solid black; padding: 2px;">No</span></p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>			
<p>21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)</p>		<p>21E. INJURY OCCURRED          While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	
<p>21F. HOW DID INJURY OCCUR?</p>			
<p>22. I certify that (I) (this hospital) attended the deceased from <span style="border: 1px solid black; padding: 2px;">7-31-72</span> to <span style="border: 1px solid black; padding: 2px;">9-24-72</span> that (I) (we) last saw the deceased alive on <span style="border: 1px solid black; padding: 2px;">9-24-72</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE  <span style="border: 1px solid black; padding: 2px;">C. S. Gentry M.D.</span></p>		<p>23B. DATE SIGNED  <span style="border: 1px solid black; padding: 2px;">9/24/72</span></p>	
<p>23C. PHYSICIAN'S NAME (Type)  <span style="border: 1px solid black; padding: 2px;">University of Md. Hospital</span></p>		<p>23D. ADDRESS  <span style="border: 1px solid black; padding: 2px;">University of Md. Hospital</span></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify)  <span style="border: 1px solid black; padding: 2px;">Burial</span></p>	<p>24B. DATE  <span style="border: 1px solid black; padding: 2px;">9-28-72</span></p>	<p>24C. NAME of CEMETERY or CREMATORY  <span style="border: 1px solid black; padding: 2px;">New Central Cem.</span></p>	<p>24D. LOCATION (City, town, or county) (State)  <span style="border: 1px solid black; padding: 2px;">Balto., Md.</span></p>
<p>25A. DATE REC'D BY HEALTH DEPT.  <span style="border: 1px solid black; padding: 2px;">SEP 26 1972</span></p>		<p>25B. NAME OF REGISTRAR  <span style="border: 1px solid black; padding: 2px;">Kelson F. Bailey</span></p>	
<p>25C. FUNERAL DIRECTOR  <span style="border: 1px solid black; padding: 2px;">1348 N. Calhoun</span></p>		<p>25D. ADDRESS  <span style="border: 1px solid black; padding: 2px;">1348 N. Calhoun</span></p>	

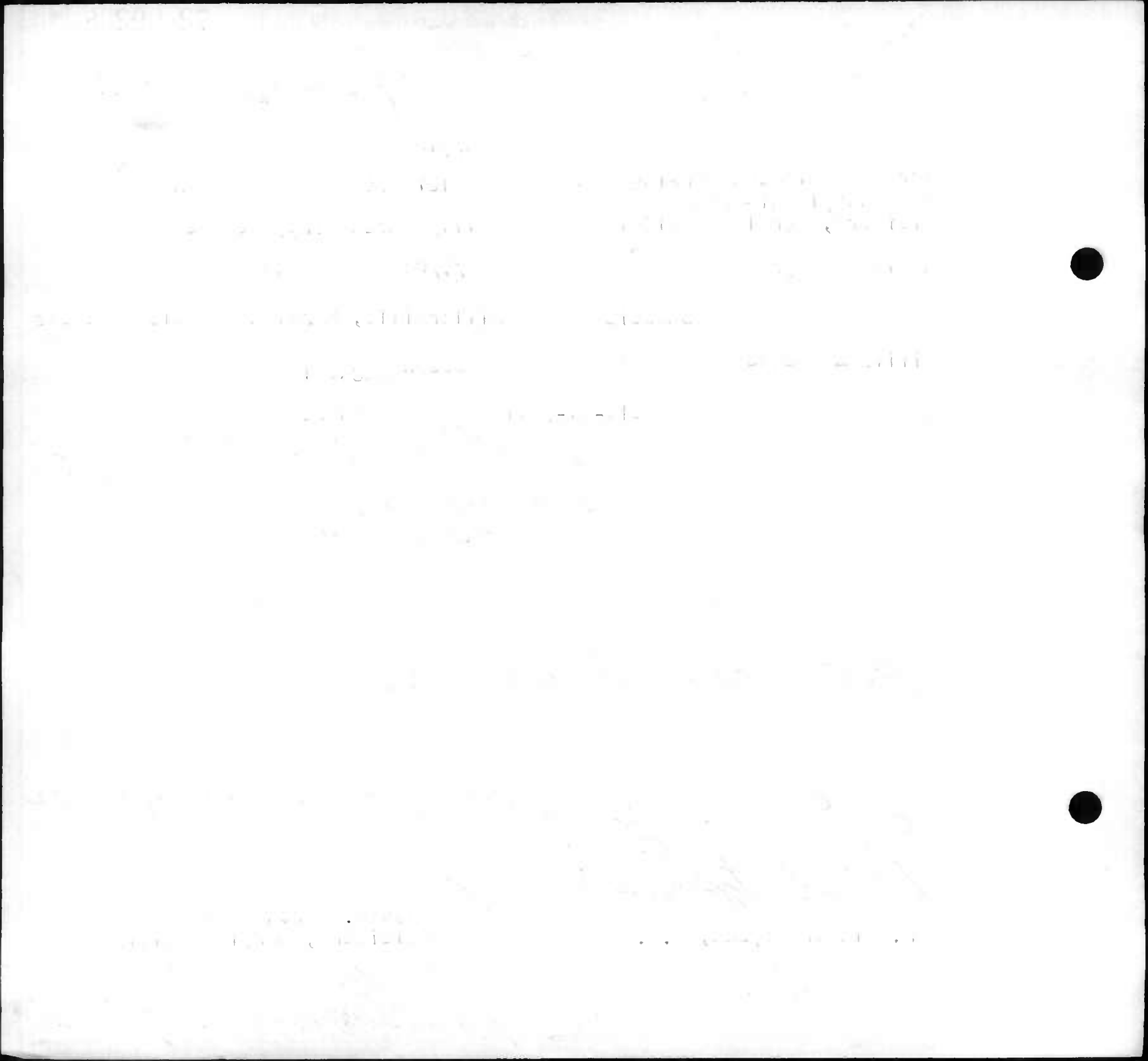




# FUNERAL DIRECTOR: IMPORTANT

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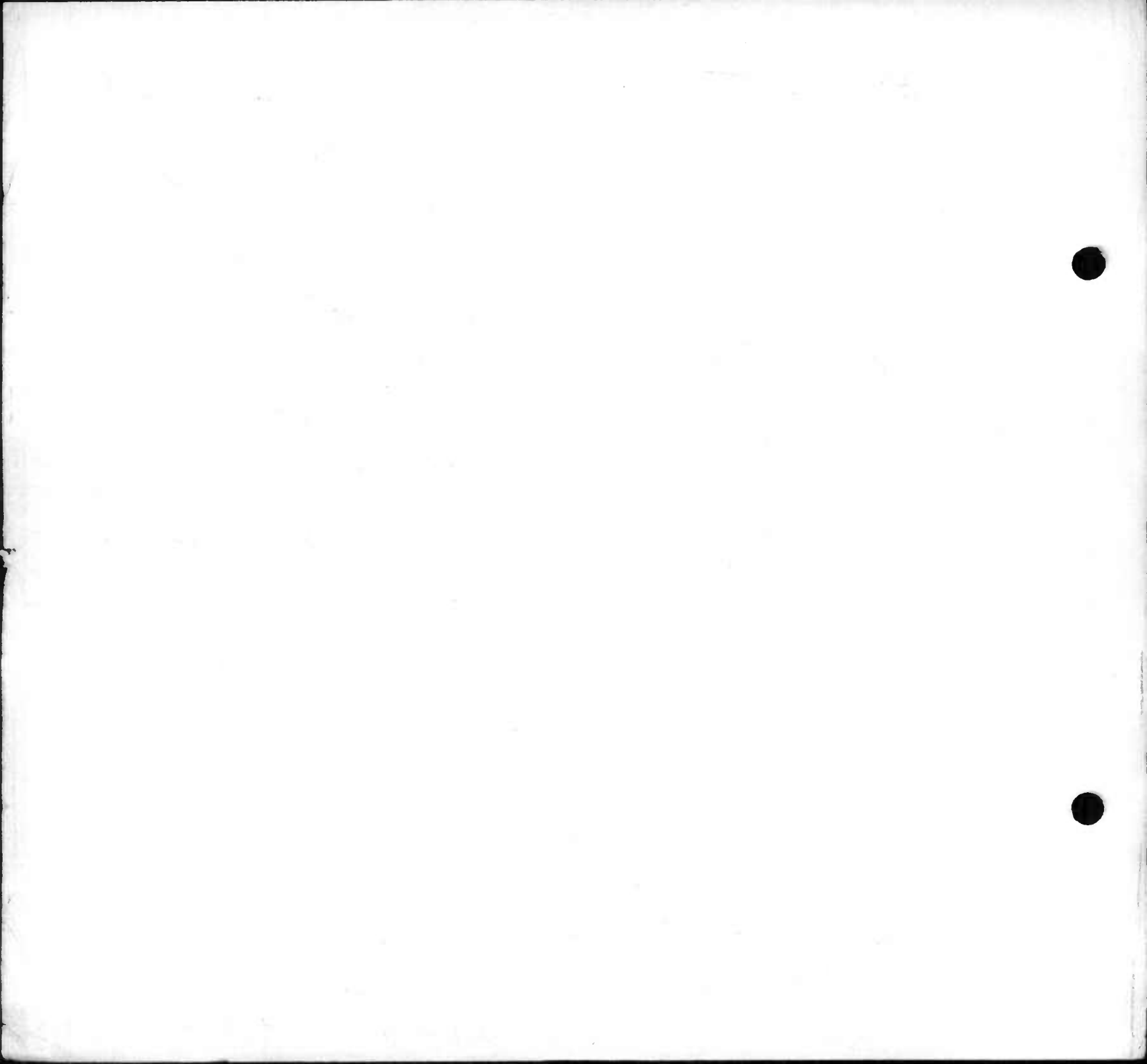
BALTIMORE CITY HEALTH DEPARTMENT		72 09208	
BIRTH NO. 72 09208		REG. NO. 72 09208	
1. NAME OF DECEASED (Type or Print) <b>GREEN, RUTH</b>		2. DATE AND HOUR OF DEATH <b>9-23-72 8:30 P</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>George Washington Nursing Home 607 Pennsylvania Avenue Baltimore, Maryland 21201</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1601</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1149 North Carey Street</b>	
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/7/06</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	9. AGE (in years last birthday) <b>65</b>
11. BIRTHPLACE (State or foreign country) <b>Millerville, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>Williamx Jacobs</b>		14. MOTHER'S MAIDEN NAME <b>Susan Mearkeal</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214-24-7941</b>	17. INFORMANT <b>Chart</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>174X1</b> <b>ADENOCARCINOMA LEFT BREAST WITH METASTASIS</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1965 7YRS.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>GENERALIZED METASTASIS</b>	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>1965</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>BREAST CANCER</b>	20A. AUTOPSY? (Yes or No) <b>NO</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>29 July 1972</b> to <b>23 Sept 1972</b> that (1) (we) last saw the deceased alive on <b>22 Sept 1972</b> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Richard Tyson, M.D.</b>		23B. DATE SIGNED <b>23 Sept 72</b>	23C. PHYSICIAN'S NAME (Type) <b>Dr. Richard Tyson, M.D.</b>
23D. ADDRESS <b>936 W. North Avenue Baltimore, Maryland 21217</b>		23E. FUNERAL DIRECTOR <b>James M. O'Leary 6839 Gilmor St</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burned</b>	24B. DATE <b>9/27/72</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Grav. Auburn</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1972</b>		25B. NAME OF REGISTRAR <b>Andrew Wilson</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-653		BALTIMORE CITY HEALTH DEPARTMENT		72 09209	
BIRTH NO.		72 09209		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
ELNORA THORNTON		9/24/72 9:44 PM.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)			
Montebello State Hospital		A. STATE <u>MARYLAND</u> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
Montebello State Hospital		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
F	B	WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH	
				5/30/14	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housekeeper				VIRGINIA, GLADSTONE	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Arthur Morris		Mary			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No				Patient's chart	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
442X1		PROBABLE		3 days	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		BROWN PNEUMONIA	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		20 MONTHS	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Left MIDDLE CEREBRAL ARTERY ANEURISM			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
9/24/72		ANEURISM		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <u>6/14/71</u> 19 <u>71</u> to <u>9/24</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>9/24/72</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
J. K. Marshall, Jr. M.D.		9/24/72		J. K. MARSHALL, JR. M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Buried		9/25/72		ARABUS MON PK	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
SEP 26 1972		Therese Wilson		Marshall P. Gayle	



72 09210

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO.

72 09210

STATE OF MARYLAND-DMH

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JOSEPH COOK, SR

2. DATE AND HOUR OF DEATH

September 18/1972 4:30 (A.M.)

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived, If institution residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

E. STREET AND NUMBER

1030 S. Hanover St.

5. SEX

Male

6. RACE

Negro

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

7/9/38

9. AGE (In years  
last birthday)

34

If Under 1 Tr.  
Months

Days

If Under 24 Hrs.  
Hours

Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

unemployed

10B. KIND OF BUSINESS OR INDUSTRY

—

11. BIRTHPLACE (State or foreign country)

U.S.A.

12. CITIZEN OF WHAT COUNTRY?

—

13. FATHER'S NAME

MAJOR COOK

14. MOTHER'S MAIDEN NAME

ITILEAN FEIDER

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

—

16. SOCIAL  
SECURITY NO.

220 36-8389

17. INFORMANT

BCH-Records

ADDRESS

4940 Eastern Avenue

Baltimore, Maryland 21224

18. 282.51

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B) Sickle cell crisis

DUE TO, OR AS A CONSEQUENCE OF:

(C) —

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Sept 15 1972 to Sept 18 1972  
that (I) (we) last saw the deceased alive on Sept 18 1972 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

John W. Kirk, M.D.

Attending  
Phys.Med.  
DirectorStaff  
Phys.

23B. DATE SIGNED

Sept. 18, 1972

23C. PHYSICIAN'S  
NAME (Type)

John W. Kirk, M.D.

23D. ADDRESS

Baltimore City Hospital

4940 Eastern Ave  
Baltimore, Maryland24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

9-22-72

24C. NAME of CEMETERY or CREMATORY

MT. CALVARY

24D. LOCATION

ANN ARUNDEL Co. MD

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

SEP 26 1972

25B. NAME OF REGISTRAR

Sidney H. Heston

25C. FUNERAL DIRECTOR

E. L. BROWN &amp; SON

ADDRESS

123 W. MONTGOMERY ST.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

THE UNIVERSITY OF

CHICAGO

LIBRARY

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 09211

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

FRANCIS B. TAYLOR

2. DATE  
OF  
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

5926 The Alameda

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

9

25

1972

2:40a

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

6. SEX

male

7. RACE

white

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

9. DATE OF BIRTH

10-11-1912

10. AGE (In years  
lost birthday)

59

If Under 1 Yr. II Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

5926 The Alameda

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Clarence C. Taylor

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Metalurgical Clerk Steel

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Rosa Shay

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

216-10-4796

18. INFORMANT

Madalene H. Taylor

ADDRESS

Same

19.

CAUSE OF DEATH

Hypertensive cardiovascular disease

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9-25-72

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

9-27-72

24C. NAME of CEMETERY or CREMATORY

Lorraine Park

24D. LOCATION (City, town, or county)

Baltimore Co.

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

SEP 26 1972

25B. NAME OF REGISTRAR

Audrey Johnston

25C. FUNERAL DIRECTOR

H. D. Jenkins &amp; Sons Co., Balto., Md.

ADDRESS

1981

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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-625		BALTIMORE CITY HEALTH DEPARTMENT		72 09212	
BIRTH NO.		72 09212		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
HERMAN GLENN PARSONS		SEPT. 19, 1972 4 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
UNIVERSITY OF MARYLAND HOSPITAL		DELAWARE V 07			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
UNIVERSITY OF MARYLAND HOSPITAL		MILLSBORO		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
		30 MAY 1930		9. AGE (In years last birthday)	
		42		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
CONTROL OPER.		DU PONT		11. BIRTHPLACE (State or foreign country)	
		DEL		12. CITIZEN OF WHAT COUNTRY?	
USA		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
J. GLENN PARSONS		BEATRICE TINGLE		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
YES		KOREAN CONF. 222-18-4081		16. SOCIAL SECURITY NO.	
		222-18-4081		17. INFORMANT	
		PEGGY L. PARSONS, MILLSBORO		ADDRESS	
		MILLSBORO		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH		HEMORRHAGE - L. FEMORAL ARTERY			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		MULTIPLE ABSCESSSES OF PELVIS & L. THIGH			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		FISTULAE FROM URETERO-SIGMOIDOSTOMY			
(C)		SIGMOIDOSTOMY			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0		CA BLADDER		NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 15 JUNE 1972 to 19 SEPT. 1972 that (I) (we) lost saw the deceased alive on 19 SEPT 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
Edward W. Campbell MD		19 Sept 1972		EDWARD W. CAMPBELL, JR.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		9/22/72		DAGSBORO CEM.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
SEP 26 1972		L. J. Whorton		G. Douglas Nelson, Brandywine, Del.	

1900

Jan 1

Feb 1

Mar 1

Apr 1

May 1

June 1

July 1

Aug 1

Sept 1

Oct 1

Nov 1

Dec 1

1901

1902

1903

1904

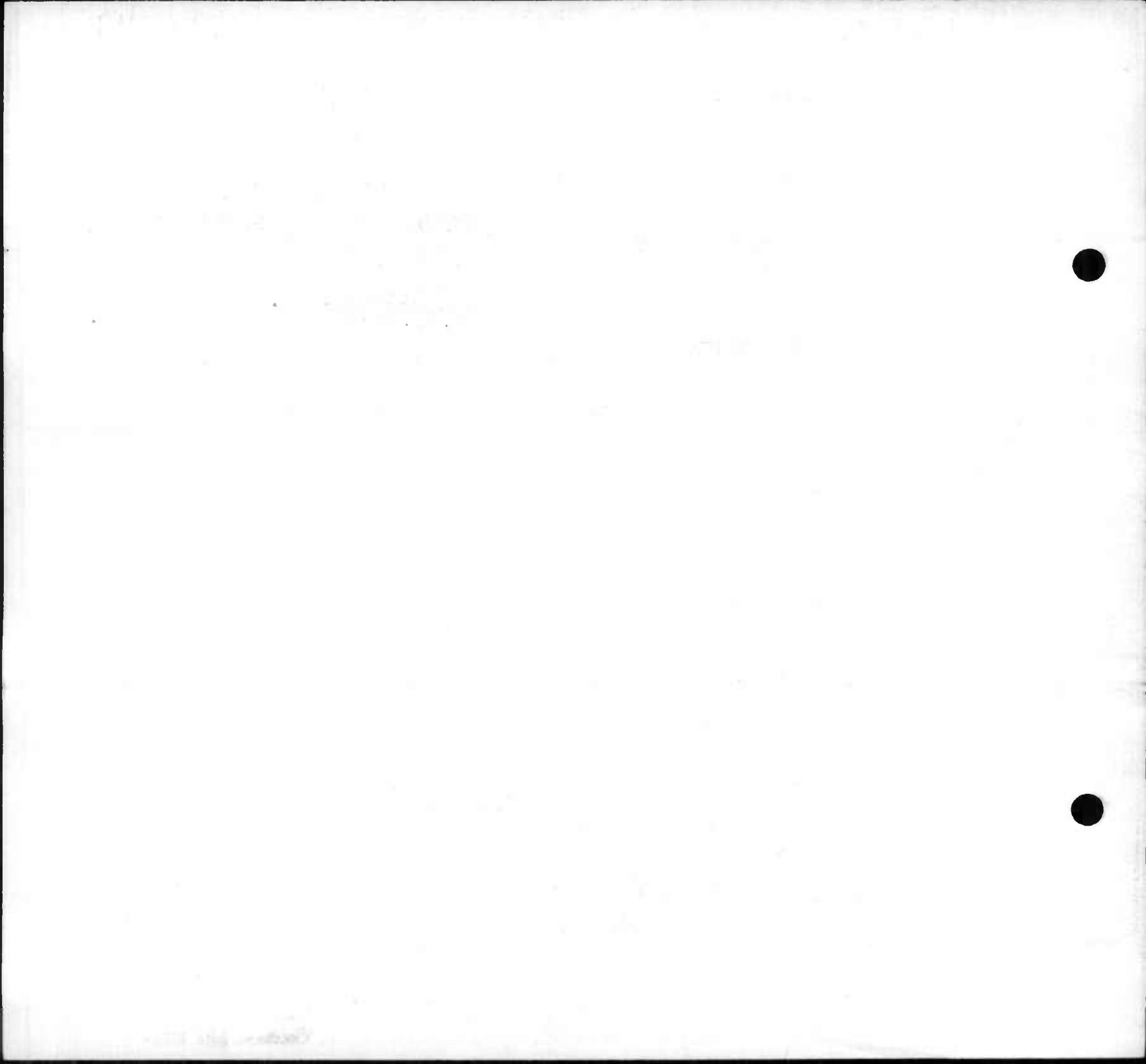
1905

1906

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

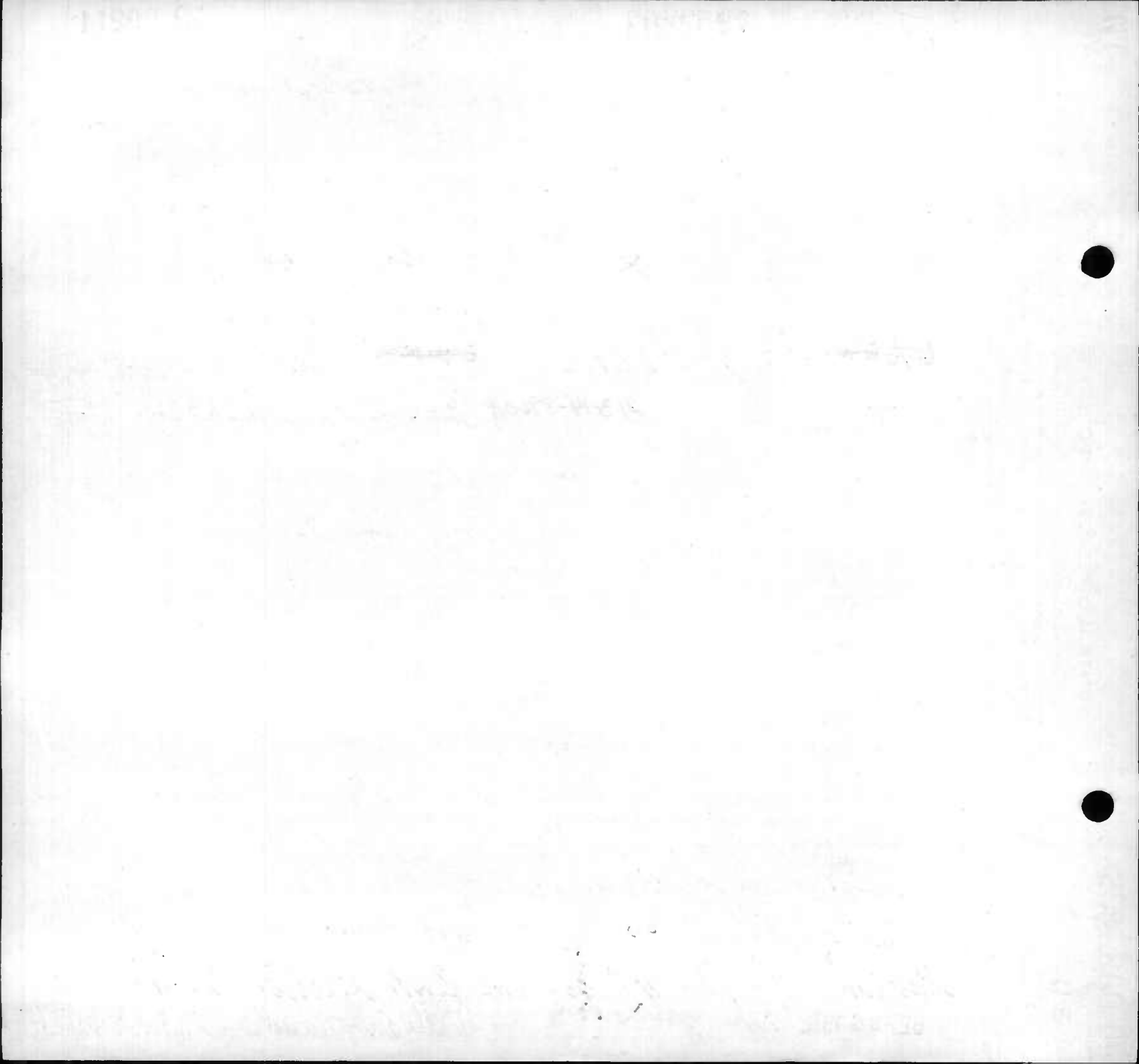
BALTIMORE CITY HEALTH DEPARTMENT		72 09213		REG. NO. 72 09213	
S-362		72 09213		STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Leng Starkey		9/24/72 5:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
University of Maryland 38 Hospital		MD Baltimore 2646			
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
♀ W					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		-		Baltimore, Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Information <sup>2</sup> Schedel not available		Information not available		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No --		220-54-9915		Hospital record -	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		pneumonia			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) _____			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
9/19/72		GICER 2 obstruction		YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
NO		None		None	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
None		White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		None	
22. I certify that (I) (this hospital) attended the deceased from 9/9/72 19 72 to 9/24/72 19 that (I) (we) last saw the deceased alive on 9/24/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Louis C. Kandl MD		9/24/72			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Louis C. Kandl MD		UNIVERSITY MD Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		9/27/72		Oak Lawn Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
SEP 26 1972		Sidney Whitton		5000 E. Baltimore St. Baltimore, MD 21224	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72 09214 STATE OF MARYLAND-DRM	
T-520 72 09214		BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Mamie Thomas</i>	
2. DATE AND HOUR OF DEATH <i>22 September 1972 6:00 P.M.</i>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>George Washington Nursing Home 607 Pennsylvania Ave.</i>			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>1802</i>		5. SEX <i>Female</i> 6. RACE <i>Negro</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
C. CITY OR TOWN <i>Balto. City</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <i>1058 W. Fayette Street</i>			
8. DATE OF BIRTH <i>8/27/06</i> 9. AGE (In years last birthday) <i>66</i>		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Beaufort N.C.</i>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <i>Wm. B. Davis</i>		14. MOTHER'S MAIDEN NAME <i>Mary Jane Davis</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>213-14-89601</i>		17. INFORMANT <i>Joel Leroy Davis</i> ADDRESS <i>Boston, Mass. 4 Esmond St.</i>	
18. <i>151.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Metastatic adenocarcinoma of the 2 mos.</i> DUE TO, OR AS A CONSEQUENCE OF: <i>Stomach</i> (C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>08-16-72</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Carcinoma of the Stomach</i>		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>none</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>none</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <i>Sept 5</i> 19 <i>72</i> to <i>Sept 22</i> 19 <i>72</i> , that (H) (we) last saw the deceased alive on <i>Sept 22</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>H. E. Bondy, M.D.</i>		23B. DATE SIGNED <i>23 Sept 72</i>		23C. PHYSICIAN'S NAME (Type) <i>H. E. Bondy</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9/26/72</i>		24C. NAME OF CEMETERY or CREMATORY <i>W. L. Babcock Park Balto. Md.</i>	
24D. LOCATION (City, town or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <i>SEP 26 1972</i>		25B. NAME OF REGISTRAR <i>Sidney M. Wooten</i>	
25C. FUNERAL DIRECTOR <i>Williamstunel Home</i>		25D. ADDRESS <i>319 W. Schenker</i>			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 09215

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>George Titter, Jr.</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>9 23 72</b> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (If not in hospital or institution, give street address or location) <b>37 Mercy Hospital</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>9 23 72 2:15 A.</b> M.			
6. SEX <b>male</b>				7. RACE <b>White</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>7/24/1921</b>				10. AGE (In years last birthday) <b>51</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>GEO. H. TITTER, SR.</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WAREHOUSE</b>	
15. MOTHER'S MAIDEN NAME <b>LILLIAN EVERETT</b>				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES</b>		17. SOCIAL SECURITY NO. <b>219-05-0167</b>	
18. INFORMANT <b>GEO. H. TITTER, SR.</b>				19. ADDRESS <b>250 DUNDAROT ST. COVERED BRIDGE LAKE WORTH, FLA.</b>		20. CAUSE OF DEATH <b>Hemorrhages of soft tissue of abdomen and chest</b>	
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Fatty metamorphosis of liver</b>				22. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Fatty metamorphosis of liver</b>				24. DATE OF OPERATION <b>2</b>			
25. CONDITION FOR WHICH OPERATION WAS PERFORMED				26. AUTOPSY? (Yes or No) <b>yes</b>			
27A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				27B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>HOUSE</b>			
27C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>612 E. Lombard St.</b>				27D. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>9 22 72 unk.</b>			
27E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				27F. HOW DID INJURY OCCUR? <b>Subject fell down steps.</b>			
28. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
29. ACTUAL SIGNATURE <b>Marvin S. Platt, M.D.</b>				30. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
31. DATE SIGNED <b>9/23/72</b>				32. DATE REC'D BY HEALTH DEPT. <b>SEP 26 1972</b>			
33. NAME OF REGISTRAR <b>Sidney H. Kohn</b>				34. FUNERAL DIRECTOR <b>412 Prince Road, Rockville, Md.</b>			
35. NAME OF CEMETERY or CREMATORY <b>LOU DON PK.</b>				36. LOCATION (City, town, or county) (State) <b>BALTO. Md.</b>			

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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09216	
G-500 72 09216				STATE OF MARYLAND-DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Paul L. Guinn		2. DATE AND HOUR OF DEATH 9/24/72	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY		M.	
FULL NAME OF HOSPITAL OR INSTITUTION Church Home & Hospital		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER Baltimore		10 S. Durham St			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10/26/1918	9. AGE (In years last birthday) 54	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) W.Va.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Howard Guinn		14. MOTHER'S MAIDEN NAME Edna Dale	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Lynch-Stacy Funeral Home Clarksburg, W.Va.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary Hemorrhage (B) DUE TO, OR AS A CONSEQUENCE OF: Generalized Metastases (C) Ca of the Lung		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr. 6 hrs. 6 min.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 19 to 9/24/72 that (I) (we) last saw the deceased alive on 9/22/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE George Richards MD		23B. DATE SIGNED 9/26/72		23C. PHYSICIAN'S NAME (Type or Print) George Richards MD	
23D. ADDRESS Greater Balto. Medical Center		23E. NAME OF REGISTRAR Sidney Johnston		23F. FUNERAL DIRECTOR Leonard J. Rack Inc. Balto. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/27/72		24C. NAME of CEMETERY or CREMATORY Greenlawn Masonic	
24D. LOCATION (City, town, or county) (State) Clarksburg, W. Va.		24E. DATE REC'D BY HEALTH DEPT. SEP 27 1972		24F. ADDRESS Clarksburg, W. Va.	

10-31 Durham St.

15080 St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09217		72 09217	
BIRTH NO.				72 09217		72 09217	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
BROSZAK, CATHERINE				SEPTEMBER 25 1972 2:45 P.M.		STATE OF MARYLAND - DUMFRIES	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY		5. CITY OR TOWN	
38 University Hospital				PENNSYLVANIA		HOMESTEAD	
6. RACE W				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-1-16	
9. SEX F				10. AGE (In years last birthday) 55		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME WILLIAM RODGER		14. MOTHER'S MAIDEN NAME JANET ANDERSON	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No NONE				16. SOCIAL SECURITY NO. 210-094565		17. INFORMANT VALENTINE BROZAK (HUSBAND)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) SEPTICAEMIA				19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: MULTIPLE ABDOMINAL ABSCESES		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 WEEK	
21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. DIABETES MELLITUS				22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). DIABETES MELLITUS		23. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 YEARS	
24. MEDICAL CERTIFICATION 19A. DATE OF OPERATION 24. DATE 25. DATE OF OPERATION 26. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED GENERALIZED PERITONITIS		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Involuntarily medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from August 29 1972 to September 25 1972 that (I) last saw the deceased alive on September 25 1972 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.							
23A. SIGNATURE William B. Long				23B. DATE SIGNED 9/25/72		23C. PHYSICIAN'S NAME (Type) William B. Long M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE SEP 29 1972		24C. NAME OF CEMETERY OR CREMATORY ST. MICHAEL CEMETERY	
24D. LOCATION (City, town, or county) (State) WEST MIFFLIN, ALLEGHENY, PENNA.				25A. FUNERAL DIRECTOR Eugene B. Long		25B. ADDRESS Baltimore, Md.	

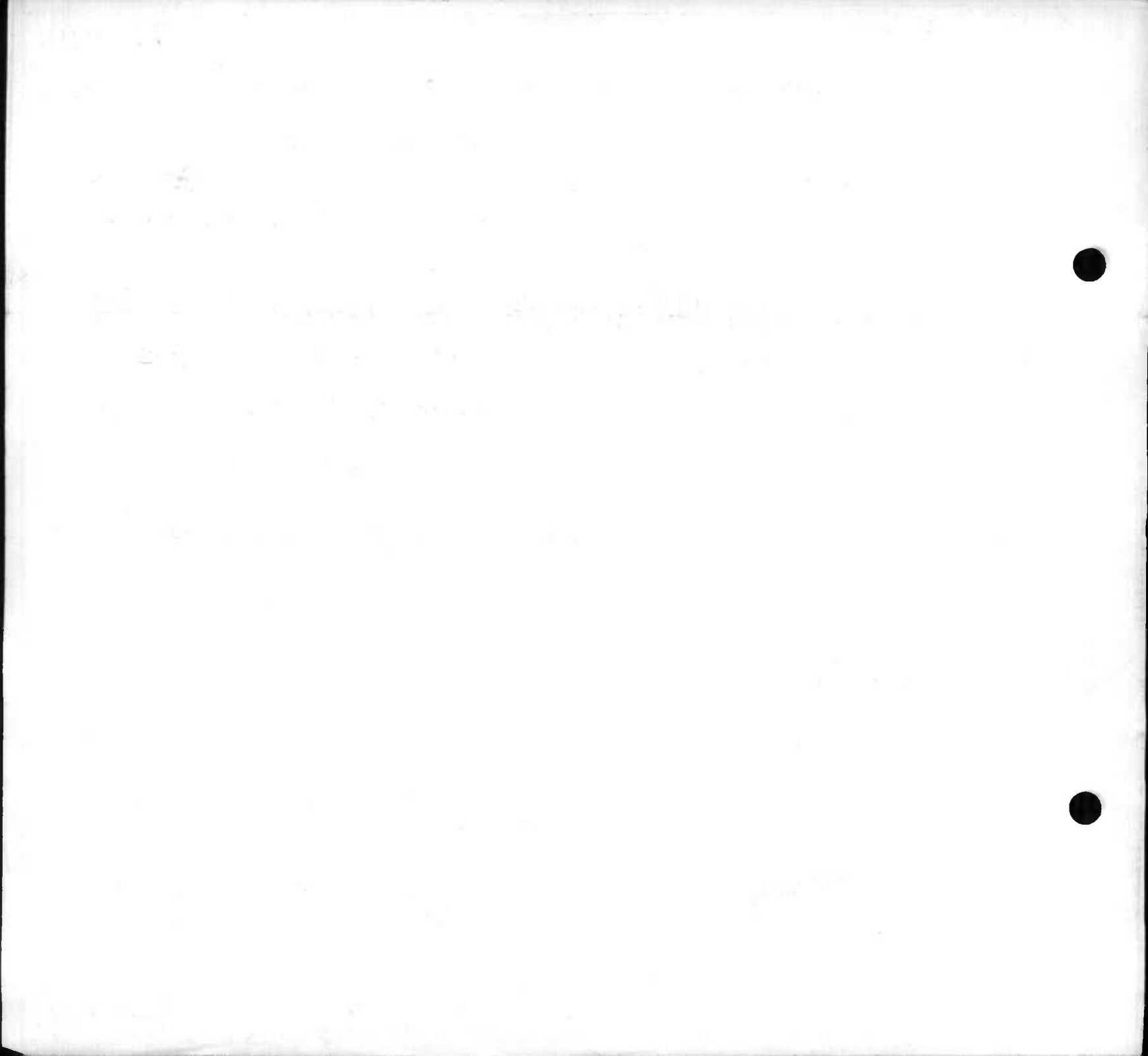
10/30/72 - operation 8/20/72

Cause - Valvulus of small bowel  
Letter from University Hospital filed  
in Bur. of Biostatistics ~~file~~

FUNERAL DIRECTOR: IMPORTANT

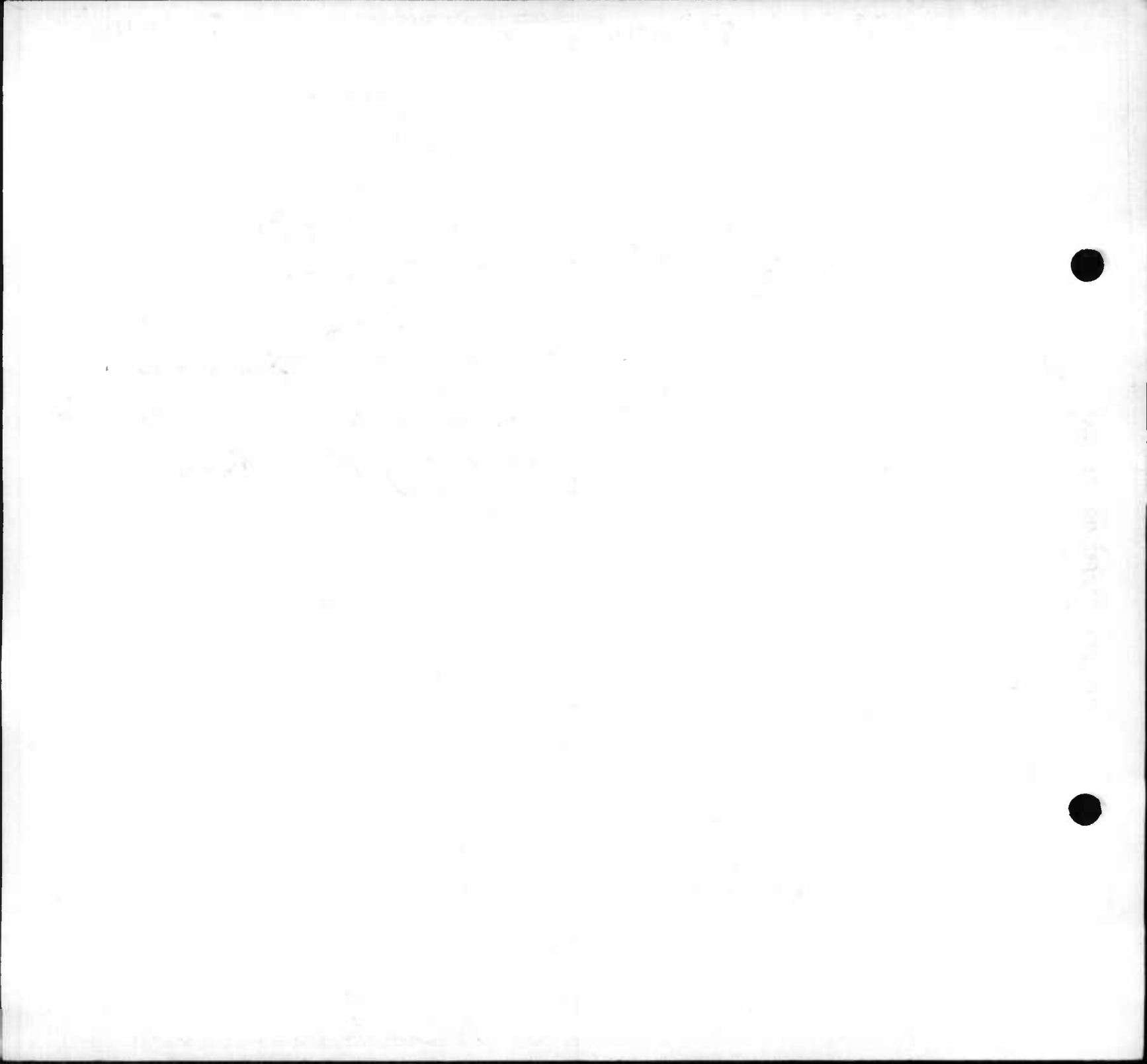
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <span style="float: right;">72 09218</span>	
E-152		72 09218					
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>HOWARD EVANS JR.</b>		2. DATE AND HOUR OF DEATH <b>9/23/72 11:30 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND - BALTO.</b> B. COUNTY <b>5300</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>CHURCH HOME &amp; HOSPITAL</b> <b>35</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <b>6000 CENTRAL AVE CATONSVILLE</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-13-25</b>	9. AGE (In years last birthday) <b>47</b>	If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Model maker U.S. Naval Ordnance</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>HOWARD EVANS</b>				14. MOTHER'S MAIDEN NAME <b>MARGARET HENNING</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) <b>YES WWII</b>				16. SOCIAL SECURITY NO. <b>218-18-4661</b>		17. INFORMANT <b>Mrs. Howard F. Evans - 6000 Central Ave 21207</b>	
18. <b>13411</b> CAUSE OF DEATH						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE <b>Cardiorespiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <b>Terminal Stage CA of Prostate</b> DUE TO, OR AS A CONSEQUENCE OF:		<b>5 mos.</b>	
(C)							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>8/23/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Intest. Work</b>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) <b>1</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>8/23 1972</b> to <b>9/23 1972</b> that (I) (we) last saw the deceased alive on <b>9/23 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>C. Vellus</b>				23B. DATE SIGNED <b>9/23/72</b>			
23C. PHYSICIAN'S NAME (Type) <b>CEASAR P. VELLUS</b>				23D. ADDRESS <b>CHURCH HOME &amp; HOSP.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-26-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loring Park Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Windsor Trl.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 27 1972</b>		25B. NAME OF REGISTRAR <b>Andrey Johnson</b>		25C. FUNERAL DIRECTOR <b>Farley-Cavanaugh Catonsville Md</b>		ADDRESS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/68





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09220		72 09220	
CERTIFICATE OF DEATH				STATE OF MARYLAND-DEMR		REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
Kirchner, Mrs. Mary		9-24-72 16:25		Maryland, (Baltimore) Jessups		M.	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
Maryland General Hospital				(Baltimore) Jessups		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER		F. CLERK		G. HOLIDAY		H. MOBILE STATES	
A B Clark Rd.							
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	01-01-90	82 Years	Housewife Own Home	Maryland.	U.S.A.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.	
Frederick J. Necker		Matilda Hoehl		NO		215 03 6930	
17. INFORMANT		ADDRESS		18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Mrs. Josephine M. Cummings, same as 4				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		1 month.	
				(B) DUE TO, OR AS A CONSEQUENCE OF:		6 days.	
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
				Gangrene of @ foot			
19. DATE OF OPERATION		20. AUTOPSY? (Yes or No)		21. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
9-12-72		Adeno Carcinoma of Rectum.		Yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 01-04-1968 to 9-24-1972 that (I) (we) last saw the deceased alive on 9-24-1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Otto R. Medinilla M.D.				9-24-72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Otto R. Medinilla M.D.				827 Linden Ave. Balto. Md. 21201			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		9/28/72		Most Holy Redeemer Cem.		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
SEP 27 1972		Sidney Whitton		David Horvath		SINGLETON FUNERAL HOME GLEN BURNIE, MD.	

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12.13.1977

12.13.1977

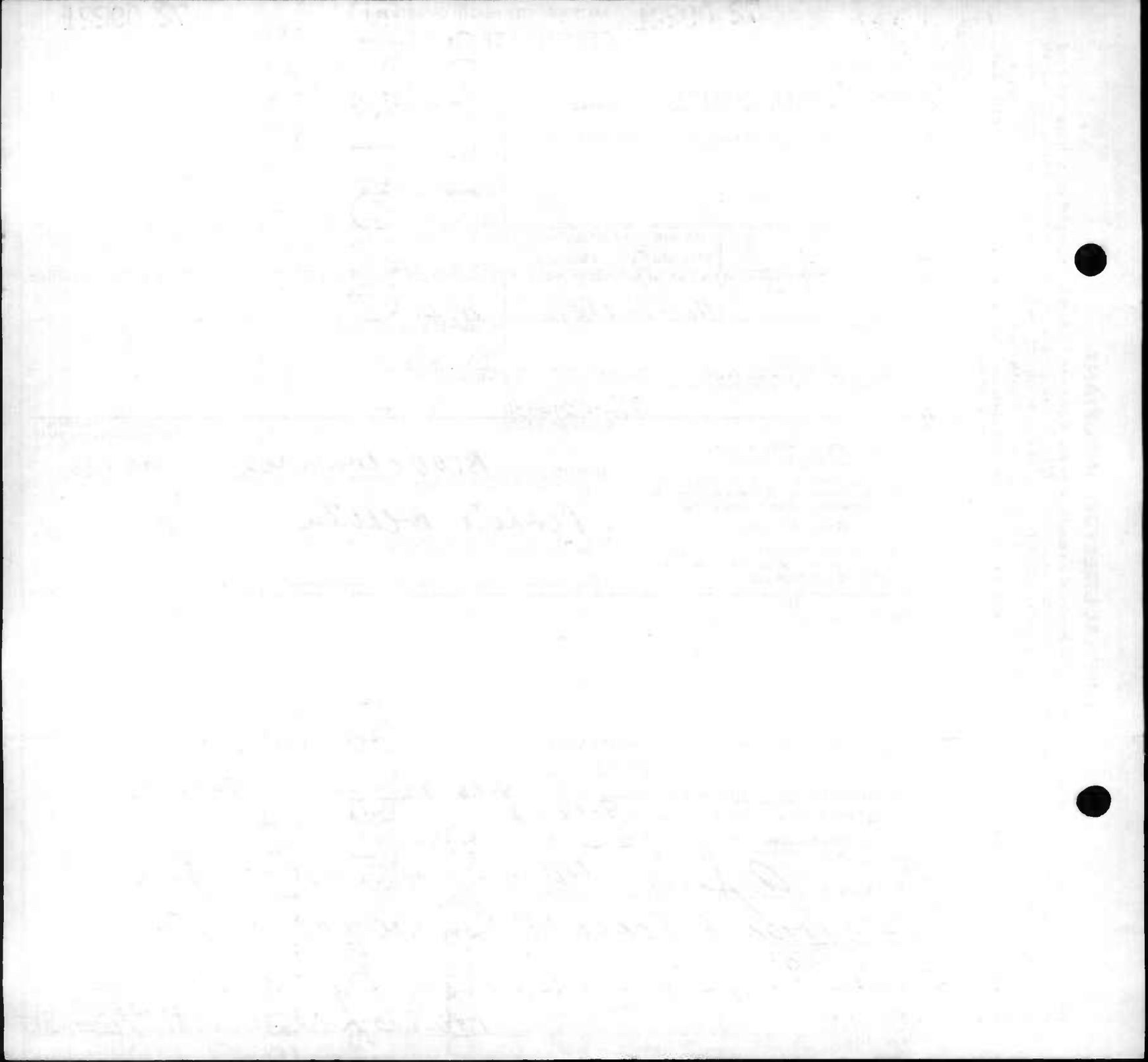
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12.13.1977

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

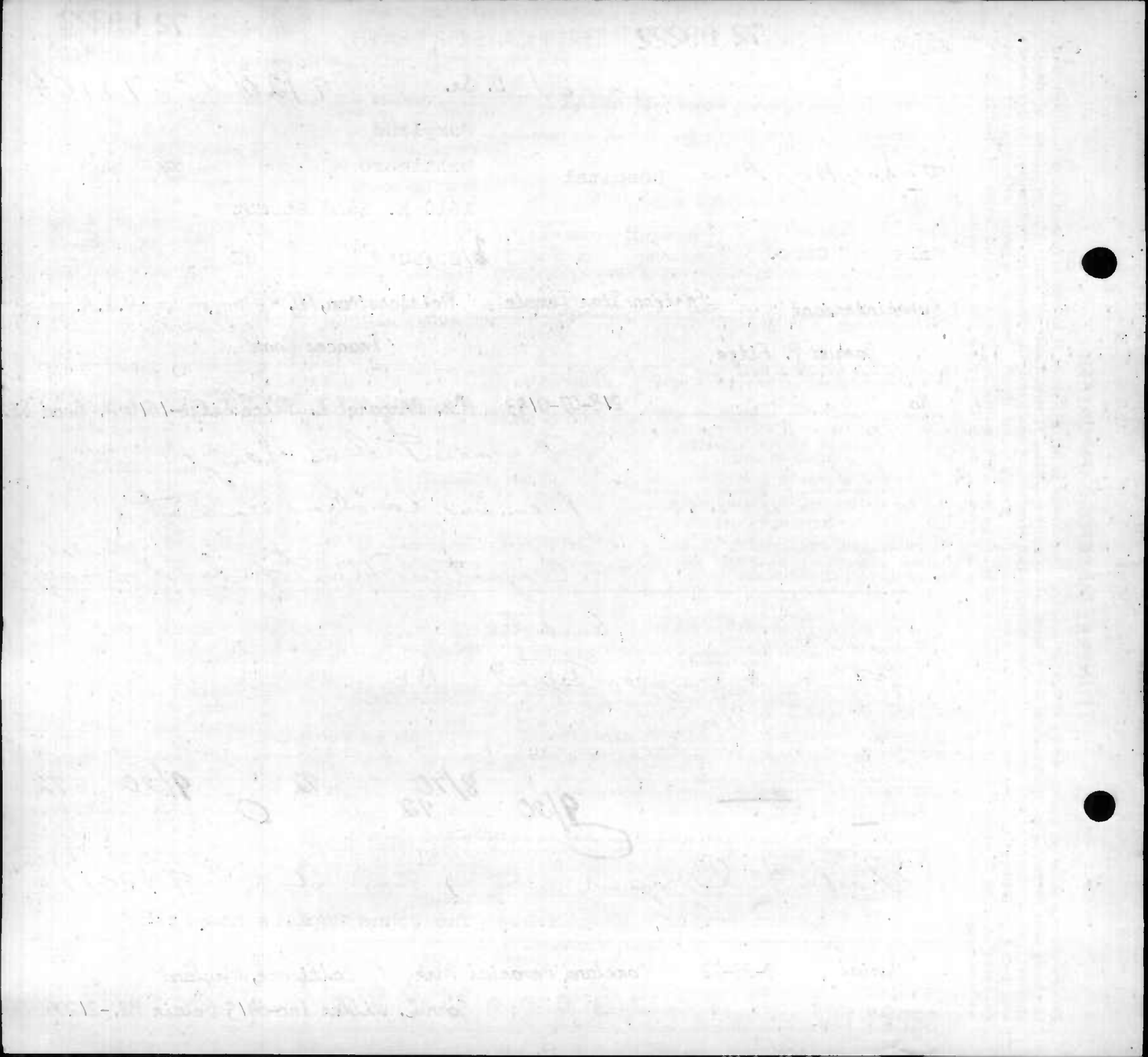
<div style="display: flex; justify-content: space-between;"> <span>W-351</span> <span>72 09221</span> </div> <div style="display: flex; justify-content: space-between;"> <span>BIRTH NO.</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> <span>72 09221</span> </div> <div style="text-align: center;"> <b>CERTIFICATE OF DEATH</b> </div>		REG. NO. _____ STATE OF MARYLAND-DEME	
1. NAME OF DECEASED (Type or Print) <u>CARRIE Wieden hoeg</u>		2. DATE AND HOUR OF DEATH <u>9-19-72</u> <u>5:30</u> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Don Secours Hosp</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>602</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>236 N Luzerne St</u>	
5. SEX <u>F</u> 6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-23-95</u> 9. AGE (In years last birthday) <u>77</u> <sup>76</sup>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> 10B. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>		11. BIRTHPLACE (State or foreign country) <u>M.D.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Henry Noels</u>		14. MOTHER'S MAIDEN NAME <u>Marie Hoesinger</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-03-4431</u>	17. INFORMANT <u>Chert</u> ADDRESS _____
18. <u>250.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>BCUD Enlarger</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Diabetes mellitus</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4000 yrs</u> <u>years ago</u>	
<b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____	
20A. AUTOPSY? (Yes or No) _____		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) _____	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) _____	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) (this hospital) attended the deceased from <u>9-16-72</u> 19 to <u>9-19-72</u> 19 that (I) (we) lost saw the deceased alive on <u>9-19-72</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>William A. Sorca MD</u>		23B. DATE SIGNED <u>9-19-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>WILLIAM A. Sorca MD</u>		23D. ADDRESS <u>Bon Secours Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/22/72</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>MT. CARMEL CEMETERY</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE</u> <u>M.D.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 27 1972</u>		25B. NAME OF REGISTRAR <u>Raymond L. Kaczorowski</u>	
25C. FUNERAL DIRECTOR <u>2525 FLEET ST.</u>		ADDRESS _____	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-320		72 09222		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 09222	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Fitze, Samuel D. Sr.</i>		2. DATE AND HOUR OF DEATH <i>9/20/72 7:10 A.M.</i>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived: If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>806</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Johns Hopkins Hospital</i> <i>33</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <i>1610 N. Bond Street</i>	
5. SEX <i>Male</i>	6. RACE <i>Cauc.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>8/02/90</i>	9. AGE (In years last birthday) <i>82</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Superintendent</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Eastern Star Temple</i>		11. BIRTHPLACE (State or foreign country) <i>Reisterstown, MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Joshua P. Fitze</i>				14. MOTHER'S MAIDEN NAME <i>Frances Cook</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-07-0193</i>		17. INFORMANT <i>Mrs. Margaret L. Price Fitze</i>		ADDRESS <i>1610 N. Bond St.</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Permanent brain damage</i>		CAUSE OF DEATH <i>Permanent brain damage</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Diabetes</i>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Previous cardiac arrest</i>		(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Coronary Heart Failure, Pulmonary Embolus?</i>		(C) <i>Coronary Heart Failure, Pulmonary Embolus?</i>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Diabetes</i>		19A. DATE OF OPERATION <i>19/51/72</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Acute Myocardial Infarction</i>		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>None</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (i) (this hospital) attended the deceased from <i>8/10</i> 19 <i>72</i> to <i>9/20</i> 19 <i>72</i> , that (i) (we) last saw the deceased alive on <i>9/20</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <i>Robert Draper</i>		23B. DATE SIGNED <i>9/20/72</i>					
23C. PHYSICIAN'S NAME (Type) <i>Robert Draper, M.D.</i>		23D. ADDRESS <i>The Johns Hopkins Hospital</i>							
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9-23-72</i>		24C. NAME OF CEMETERY or CREMATORY <i>Moreland Memorial Park</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 27 1972</i>		25B. NAME OF REGISTRAR <i>Andrew W. Miller</i>		25C. FUNERAL DIRECTOR <i>John D. Miller Inc</i>		ADDRESS <i>6415 Belair Rd. - 21206</i>			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 09223

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>LEONARD STEVEN CALISH</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 9-23 72 4:34 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>40 St. Agnes Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>September 23, 72 4:34 P. M.</b>	
6. SEX <b>Male</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE <b>White</b>		C. CITY OR TOWN <b>Columbia</b>	
9. DATE OF BIRTH <b>Jan 8, 1964</b>		10. AGE (In years last birthday) <b>8</b>	
11. BIRTHPLACE (State or foreign country) <b>Boston, Mass</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>School</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
13. FATHER'S NAME <b>Troy Calish</b>		15. MOTHER'S MAIDEN NAME <b>Clare Bernstein</b>	
18. INFORMANT <b>Troy Calish - same</b>		ADDRESS	
19. <b>E 884 X1</b>		CAUSE OF DEATH <b>Multiple injuries with laceration</b>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE of liver and spleen DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) _____ DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) _____	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? <b>Front yard 10741 Evening Wind Court</b>		22D. TIME OF INJURY (APPROX.) <b>9-23-72 3:30 P</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Fell out of tree</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Marvin S. Platt</b> M.D. EXAMINER'S NAME (Type) <b>Marvin S. Platt, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>September 24, 1972</b>			
24A. BURIAL OR CREMATION REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/26/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Sharon Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Boston Mass</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 27 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Johnston</b>	
25C. FUNERAL DIRECTOR <b>6010 Reisterstown Rd.</b>		ADDRESS	



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**FUNERAL DIRECTOR: IMPORTANT**

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BALTIMORE CITY HEALTH DEPARTMENT				72 09224		72 09224	
72 09224				72 09224		72 09224	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
H-165				STATE OF MARYLAND-DEPT			
Samuel Hoberman				SEPT. 23, 1972 @ 6:35 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
Jewish Convalescent and Nursing Home				State, Md. Apt 101 State, Md.			
4601 Pall Mall Rd				C. CITY OR TOWN			
Balto 21215, Maryland				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER				6602 Vincent Lane Apt 101 2831			
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
MALE		WHITE		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		4-15-88	
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
84		SELF EMPLOYED		RUSSIA		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
TZVI HOBERMAN				FRIEDA ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO						RABBI ZEV HOBERMAN, 1017 SMOKE TREE ROAD #8	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
412-415-168-1				Ventricular fibrillation Terminal			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Arteriosclerotic C-V Disease years			
II				(C) atrial fibrillation years			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Parkinsonism years			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
0				Benchoogenic Carcinoma several months			
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (APPROX.)			
21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?			
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (the hospital) attended the deceased from February 1962 to September 23 1972, that (I) (we) last saw the deceased alive on 9/13/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Louis R. Maser M.D.				9/23/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
LOUIS R. MASER M.D.				2724 SMITH AVE BALTIMORE MD.			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE			
BURIAL				9/25/72			
24C. NAME OF CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)			
SHOMREI MISHMERES				ROSEDALE, MARYLAND			
25A. DATE REC'D BY HEALTH DEPT				25B. NAME OF REGISTRAR			
SEP 27 1972				Sol Levinson & Bros., 6010 REISTERSTOWN RD			
25C. FUNERAL DIRECTOR ADDRESS							

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STATE OF MARYLAND-DEATH				BALTIMORE CITY HEALTH DEPARTMENT			
72 09225				72 09225			
S-000				MEDICAL EXAMINER'S CERTIFICATE OF DEATH			
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type of death) <b>HARRIETT A (HELEN) SHAW</b>				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 3821 Garrison Blvd.</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>9 25 1972 11:15a M.</b>			
6. SEX <b>female</b>				5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1510</b>			
7. RACE <b>negro</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>1-9-37</b>		10. AGE (In years last birthday) <b>35</b>		E. STREET AND NUMBER <b>3821 Garrison Blvd.</b>			
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Harry Surratt</b>			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <b>Vergie Phillips</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS <b>Rose A. Wilson 2306 Aisquith Street</b>			
19. <b>57118 I</b> CAUSE OF DEATH <b>Fatty liver</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION <b>1</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b> M.D. EXAMINER'S NAME (Type) DATE SIGNED <b>9-25-72</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-28-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 27 1972</b>		25B. NAME OF REGISTRAR <b>2000</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Wm O March 928 E North Ave.</b>			

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UNITED STATES DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C.

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

UNITED STATES DEPARTMENT OF AGRICULTURE

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-650		72 09226		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.		72 09226	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) RICHARD BROWN		2. DATE AND HOUR OF DEATH 9.24.72		STATE OF MARYLAND - DEMO		8.10 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY U.S.A.		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL 44				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 320 E. 20TH STREET			
5. SEX M	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 05-02-37	9. AGE (In years last birthday) 35	10. If Under 1 Yr. Months: Days: Hours: Min.		11. If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNEMPLOYED				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) S. CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CAIL BROWN				14. MOTHER'S MAIDEN NAME MARTHA JAMES					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 248-50-9449		17. INFORMANT MARTHA GURLEY		ADDRESS 2412 GUILFORD AVE	
18. 250.914303.2 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: METABOLIC BRAIN DAMAGE				3 DAYS	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				(B) ACID BASE IMBALANCE				3 DAYS	
				(C) DIABETES MELLITUS				9 YEARS.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				INANITION - CHRONIC ALCOHOLISM					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 9.21.1972 to 9.24.1972, that (I) (we) last saw the deceased alive on 9.24.1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE [Signature]				23B. DATE SIGNED 9.24.72					
23C. PHYSICIAN'S NAME (Type) CARLOS H. SANTILLAN				23D. ADDRESS 33rd and CALVERT STREETS					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-29-72		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. SEP 27 1972		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR VIVIAN C. MARCH		ADDRESS 928 E. NORTH			





CERTIFICATE OF DEATH

REG. NO. 72 09227  
STATE OF MARYLAND-DEM

L-520 72 09227

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>INNOCENT J. LINZ</b> (Last Name is LINZ)		2. DATE AND HOUR OF DEATH <b>9/24/72 7:05 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>4940 Eastern Ave. Baltimore, Md. 21224</b>				C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>3707 FAIR Ave. 21224</b>					
5. SEX <b>Male</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/3/96</b>	9. AGE (In years last birthday) <b>76</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Boiler Maker</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Boiler Maker</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>STAND. OIL CO. OIL INDUSTRY</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD.</b>
13. FATHER'S NAME <b>ANDREW LINZ</b>			14. MOTHER'S MAIDEN NAME <b>ANNA MUTH.</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES</b>		16. SOCIAL SECURITY NO. <b>215-05-5155</b>		17. INFORMANT <b>Records: BCH-4940 Eastern Ave. 21224</b>	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. If means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cardio Respiratory Arrest</b>					
(B) <b>Conjunctive heart failure, Pulmonary</b>					
(C) <b>Previous MI</b>					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>45 minutes</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>NONE</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/21/72</b> 1972 to <b>9/24</b> 1972, that (I) (we) last saw the deceased alive on <b>9/24</b> 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Richard L. Sylvan MD.</b>				23B. DATE SIGNED <b>9/24/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Richard L. Sylvan MD</b>				23D. ADDRESS <b>BAL 4940 Eastern Ave., 21224 Baltimore, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>9-27-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>FAIRFAX HEART CEM.</b>	
24D. LOCATION (City, town, or county) (State) <b>7401 GERMAN HILL RD. BALTIMORE, MD.</b>		25A. FUNERAL DIRECTOR'S NAME (Type) <b>SEP 27 1972</b>			
25B. NAME OF REGISTRAR <b>Sandra W. Houston</b>		25C. FUNERAL DIRECTOR'S ADDRESS <b>901 S CONKLING ST. BALTO, 21224, MD.</b>			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1-23-52

25 10557

25 10557

IN RE: J. L. L. S.

12/1/52

270

BALTIMORE

3rd FRI

3d of 2d

BALTIMORE, MD.

ANNA MUTH.

STAND OIL CO.

Robert Parker

ANDREW L. L. S.

212-02-2122

W. L. I.

Yes

BURIAL 9-21-52 SACRED HEART CH. 1401 GERMANY AVE. TO BAL.

Charles J. ...

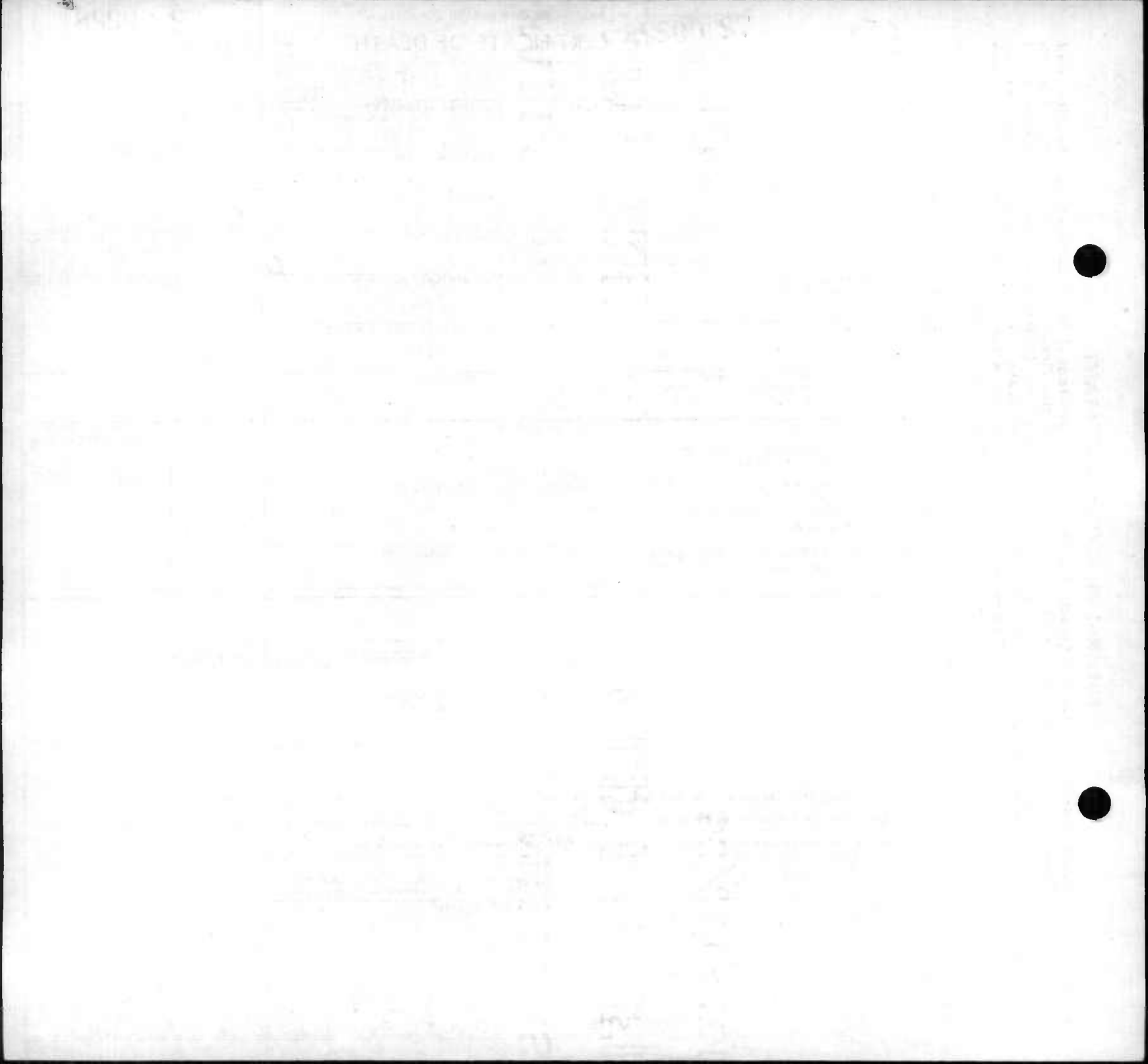
212-02-2122



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-655		72 09228		BALTIMORE CITY HEALTH DEPT.		72 09228	
BIRTH NO.		72 09228				72 09228	
1. NAME OF DECEASED (Type or Print) <b>Freeman Robert</b>				2. DATE AND HOUR OF DEATH <b>9/25/72 19:33 A M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>Johns Hopkins</b> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1402</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>609 Pitcher St. 21217</b>			
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/17/01</b>	9. AGE (in years last birthday) <b>70</b>	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Tractor Operator</b>		11. BIRTHPLACE (State or foreign country) <b>Tarborough, N.C.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>	
13. FATHER'S NAME <b>Anthony Freeman</b>				14. MOTHER'S MAIDEN NAME <b>Martha Sherrod</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <b>No</b>		16. SOCIAL SECURITY NO. <b>217-01-4410</b>		17. INFORMANT <b>Wife GRACE Freeman</b> ADDRESS <b>Pitcher St. -609</b>			
18. <b>427.2 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardio Resp. Arrest</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Cardiogenic Shock</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>1 1/2 hrs</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes.</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>9/17</b> 19 <b>72</b> to <b>9/25</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>9/25</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>J. Raymond DePaulo</b>				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <b>J. Raymond DePaulo</b>	
23D. ADDRESS <b>Johns Hopkins Hospital</b>				23E. DATE REC'D BY HEALTH DEPT. <b>SEP 27 1972</b>		23F. NAME OF REGISTRAR <b>Sidney Whitman</b>	
23G. NAME OF FUNERAL DIRECTOR <b>Robert F. H. 1701 - Laurens St.</b>				23H. ADDRESS		23I. DATE OF REMOVAL (Specify) <b>9-28-72</b>	
23J. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>				23K. LOCATION (City, town, or county) <b>Ba 1 to, Md</b>		23L. STATE (State) <b>Md</b>	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT		72 09229		72 09229	
BIRTH NO. <b>S-580</b>		72 09229		REG. NO. <b>72 09229</b>	
<b>CERTIFICATE OF DEATH</b>		<b>STATE OF MARYLAND-DHMH</b>			
1. NAME OF DECEASED (Type or Print) <b>Smith, Myrtle</b>		2. DATE AND HOUR OF DEATH <b>September 20, 1972 9:05 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>THE GOOD SAMARITAN HOSPITAL</b> <b>45</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2739</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>4619 Northwood Dr.</b>			
5. SEX <b>Female</b>	6. RACE <b>Black</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>03-04-88</b>	9. AGE (In years last birthday) <b>84</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>John Brown</b>		14. MOTHER'S MAIDEN NAME <b>Mary ?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215249679</b>		17. INFORMANT <b>Benjamin B. Smith</b> ADDRESS <b>Same</b>	
18. <b>712.41</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <b>CVA</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 mo</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>6-20</b> 1972 to <b>9-20</b> 1972 that (I) (we) last saw the deceased alive on <b>9-20</b> 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Richard J. Wells MD</b>		23B. DATE SIGNED <b>9/20/72</b>		23C. PHYSICIAN'S NAME (Type) <b>Richard J. Wells MD</b>	
23D. ADDRESS <b>1000 Broadway Ave.</b>		23E. FUNERAL DIRECTOR <b>Elmer O. Wilson</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-28-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arboretum</b>	
24D. LOCATION (City, town, or county) (State) <b>Arboretum Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 27 1972</b>			
25B. NAME OF REGISTRAR <b>Andrew H. H. H.</b>		25C. ADDRESS <b>1000 Broadway Ave.</b>			



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				72 09230
72 09230 CERTIFICATE OF DEATH				REG. NO. 72 09230
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
Lizette Wells		Sept. 18 <sup>th</sup> 1972 11 55 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
46 Lutheran Hosp.		A. STATE Maryland B. COUNTY 2037		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN		D. INSIDE CITY LIMITS?
46 Lutheran Hosp.		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER		3923 Edmondson Ave.		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)
Female	Colored		Apr. 10 1914	58
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
Housewife		None		Sumter, S. C.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?
		Jazie Lemon		U.S.A.
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT
No		213-12-2384		Ethel Brown
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		ACUTE CARDIOVASCULAR DISEASE		
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: PULMONARY EDEMA.		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: ASCVD		
II		(C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
0				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 9/5 1972 to 9/18 1972, that (I) (we) lost saw the deceased alive on 9/18 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.				
23A. SIGNATURE		23B. DATE SIGNED		
Norman R Kleiman		9/21/72		
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
NORMAN R KLEIMAN		3803 EDMONDSON AVE		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY
Burial		9-23-72		MT. Auburn Cem.
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR
SEP 27 1972		Sidney H. Wilson		Charles O. Wilson
				1000 Brantley Ave.

1. The first part of the report is a general description of the project. It includes a statement of the purpose of the project, a description of the methods used, and a summary of the results. The second part of the report is a detailed description of the results. It includes a discussion of the data, a comparison of the results with previous work, and a conclusion. The third part of the report is a list of references. It includes a list of the books and articles that were used in the project.

2. The first part of the report is a general description of the project. It includes a statement of the purpose of the project, a description of the methods used, and a summary of the results. The second part of the report is a detailed description of the results. It includes a discussion of the data, a comparison of the results with previous work, and a conclusion. The third part of the report is a list of references. It includes a list of the books and articles that were used in the project.

3. The first part of the report is a general description of the project. It includes a statement of the purpose of the project, a description of the methods used, and a summary of the results. The second part of the report is a detailed description of the results. It includes a discussion of the data, a comparison of the results with previous work, and a conclusion. The third part of the report is a list of references. It includes a list of the books and articles that were used in the project.

4. The first part of the report is a general description of the project. It includes a statement of the purpose of the project, a description of the methods used, and a summary of the results. The second part of the report is a detailed description of the results. It includes a discussion of the data, a comparison of the results with previous work, and a conclusion. The third part of the report is a list of references. It includes a list of the books and articles that were used in the project.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JAMES MC PHERSON</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>46 Lutheran Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour M. <b>9 25 1972 6:49a</b>	
6. SEX <b>male</b>		7. RACE <b>negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years last birthday) <b>49</b>		E. STREET AND NUMBER <b>2221 Roslyn Ave.</b>	
11. BIRTHPLACE (State or foreign country) <b>Florida, U.S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ben McPherson</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME <b>Beatrice James</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes</b>	
17. SOCIAL SECURITY NO. <b>238-26-7682</b>		18. INFORMANT <b>Matthe J. McPherson</b>	
19. <b>571-80</b>		ADDRESS <b>Since</b>	
CAUSE OF DEATH <b>Fatty liver</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>HEAD &amp; ABDOMEN</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Russell S. Fisher</b> M.D. EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b> DATE SIGNED <b>9-25-72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-29-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Calverton</b>		24D. LOCATION (City, town, or county) (State) <b>Calverton Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 27 1972</b>		25B. NAME OF REGISTRAR <b>Arthur J. McPherson</b>	
25C. FUNERAL DIRECTOR <b>Ben J. McPherson</b>		ADDRESS <b>Ben J. McPherson</b>	



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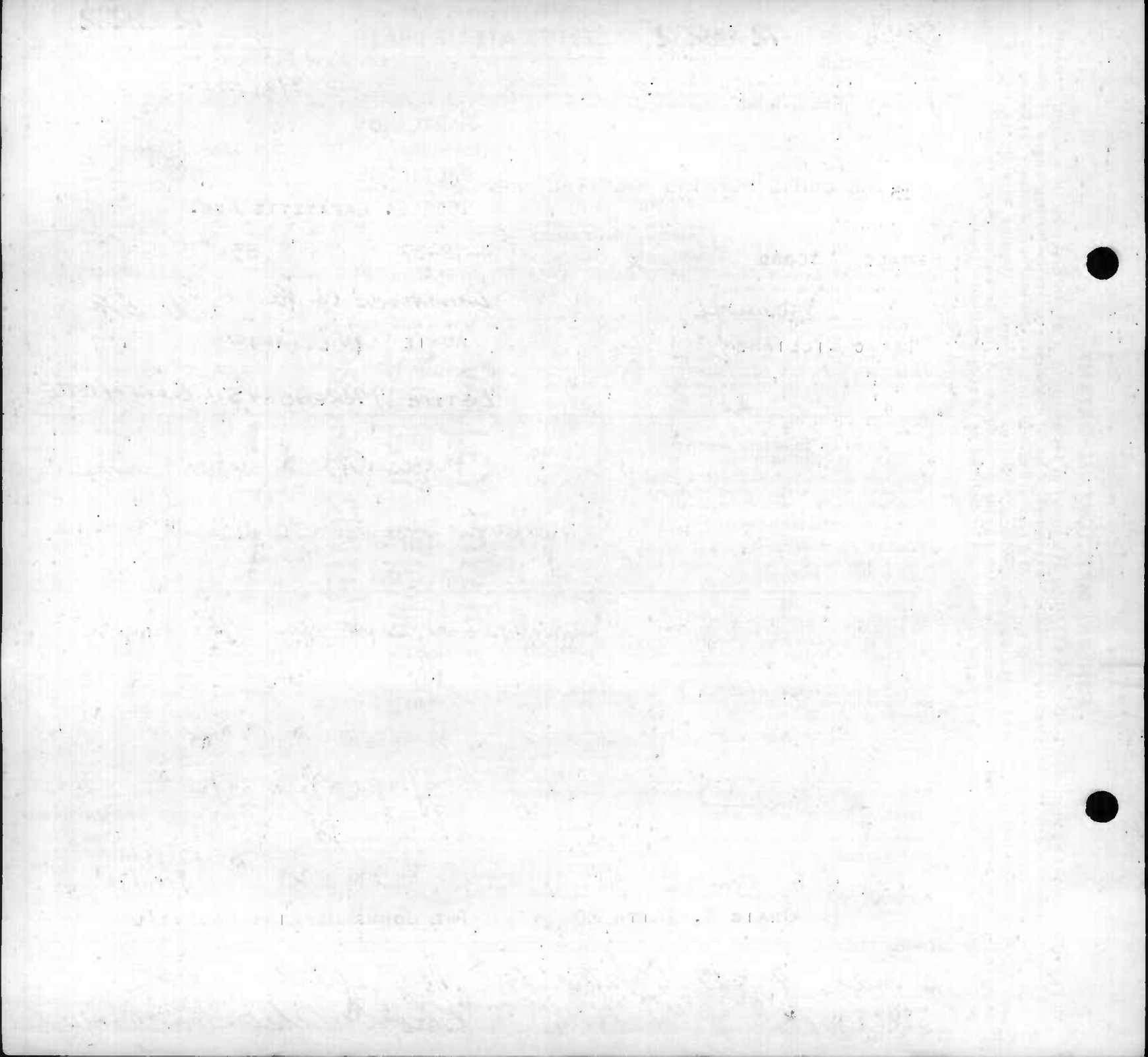
13500 50



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

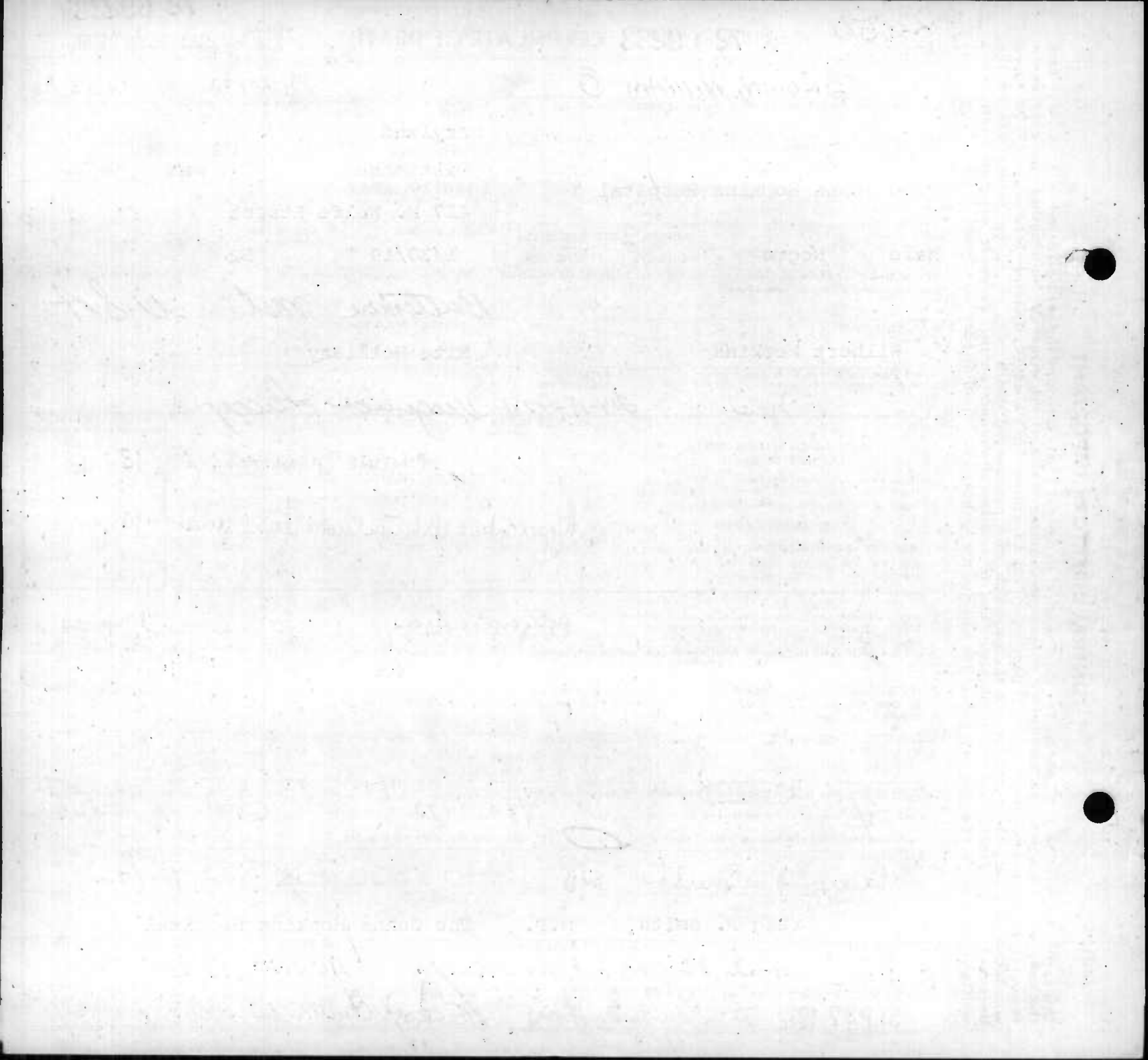
BALTIMORE CITY HEALTH DEPARTMENT				72 09232		72 09232	
BIRTH NO.				72 09232		72 09232	
1. NAME OF DECEASED (Type or Print) <b>BILLBROW, FANNIE</b>				2. DATE AND HOUR OF DEATH <b>9/21/72 5:45 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>33 THE JOHNS HOPKINS HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>806</b>			
5. SEX <b>FEMALE</b>				6. RACE <b>NEGRO</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <b>4-18-87</b>	
13. FATHER'S NAME <b>ISAAC WILLIAMS</b>				14. MOTHER'S MAIDEN NAME <b>ANNIE WILLIAMS</b>		9. AGE (In years last birthday) <b>85</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country) <b>LANCASTER Co. Va.</b>	
17. INFORMANT <b>LETTIE MORENO 1511 E. LAFAYETTE AVE.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
18. <b>410.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>Myocardial infarction</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Myocardial infarction</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>	
18. <b>410.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>Myocardial infarction</b>				CAUSE OF DEATH (B) <b>Hypertensive arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF: <b>30-40 yrs.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30-40 yrs.</b>	
18. <b>410.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>Myocardial infarction</b>				CAUSE OF DEATH (C) <b>Hypoglycemia, dysphagia</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>II</b>				19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/17/1972</b> to <b>9/21/1972</b> , that (I) (we) last saw the deceased alive on <b>9/21/1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE <b>Craig R. Smith MD</b>		23B. DATE SIGNED <b>9/21/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>CRAIG R. SMITH MD</b>				23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>		23E. DATE SIGNED <b>9/21/72</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>9-26-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Catholics Cent</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>9-26-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Catholics Cent</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>9-26-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Catholics Cent</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 27 1972</b>				25B. NAME OF REGISTRAR <b>Audrey H. H. H. H.</b>		25C. FUNERAL DIRECTOR <b>Elroy D. Wilson 1000 Maryland Ave</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-650 72 09233 CERTIFICATE OF DEATH				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09233 STATE OF MARYLAND-DEMH	
1. NAME OF DECEASED (Type or Print) <b>Brown, William O</b>				2. DATE AND HOUR OF DEATH <b>9/20/72 10:15 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>The Johns Hopkins Hospital</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>604</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>417 N. Wolfe Street</b>			
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/30/19</b>	9. AGE (In years last birthday) <b>53</b>	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) <b>Baltimore Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		
13. FATHER'S NAME <b>Wilbert Meekins</b>			14. MOTHER'S MAIDEN NAME <b>Rita Holliday</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes</b>			16. SOCIAL SECURITY NO. <b>214-18-9281</b>		17. INFORMANT <b>Virginia Lacey</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>412.1</b> <b>PONTINE Hemorrhage</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>PONTINE Hemorrhage</b> (B) <b>Hypertensive Arteriosclerotic heart disease</b> (C) <b>polycythemia</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>13 days</b> <b>10 years</b> <b>10 years</b>		
19. DATE OF OPERATION <b>2</b>			20. AUTOPSY? (Yes or No) <b>Yes</b>		21. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO</b>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>9/7 19 72</b> to <b>9/20 19 72</b> , that (I) (we) lost saw the deceased alive on <b>9/20 19 72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Craig R. Smith MD</b>						23B. DATE SIGNED <b>9/20/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Craig R. Smith, M.D.</b>			23D. ADDRESS <b>The Johns Hopkins Hospital</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>9-26-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>MT CALVARY</b>		24D. LOCATION (City, town, or county) (State) <b>ARUNDEL CO Md,</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 27 1972</b>			25B. NAME OF REGISTRAR <b>Audrey Johnston</b>		25C. FUNERAL DIRECTOR <b>ECROY O. WILSON 1000 BRANTLEY AVE</b>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">72 09234</span>	
K-200 72 09234				CERTIFICATE OF DEATH	
BIRTH NO.				STATE OF MARYLAND-DEME	
1. NAME OF DECEASED (Type or Print) <b>Bernard Gebhard Keys</b>			2. DATE AND HOUR OF DEATH <b>9/24/1972 3:45 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Maryland General Hospital</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <b>3338 Ravenwood Ave.</b>					
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/30/1891</b>	9. AGE (In years last birthday) <b>81</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>JOHN WALTER KEYS</b>			14. MOTHER'S MAIDEN NAME <b>ANGIE LEIMBACH</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214-16-5063</b>		17. INFORMANT <b>MRS ETHEL M. KEYS</b> ADDRESS <b>3338 Ravenwood Ave.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Respiratory and circulatory failure of central origin</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3-4 hours</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cerebrovascular Accident</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>7 days</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>9/24/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/18/72</b> to <b>9/24/72</b> that (I) (we) last saw the deceased alive on <b>9/24/72</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Hyo-yun Yun M.D.</b>				23B. DATE SIGNED <b>9/24/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Hyo-yun Yun</b>				23D. ADDRESS <b>Maryland General Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		24B. DATE <b>9/25/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Security Process INC.</b>	
24D. LOCATION (City, town, or county) <b>Catonsville Maryland</b>		(State)			
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 27 1972</b>		25B. NAME OF FUNERAL DIRECTOR <b>Henry Sander &amp; Sons Inc.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Balto. Md.</b>	





STATE OF MARYLAND-DEMH  
BALTIMORE CITY HEALTH DEPARTMENT  
L-520 72 09235  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
REG. NO. 72 09235

BIRTH NO.		1. NAME OF DECEASED (Type or Print) FRANKLIN D. LONG		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 1238 E. Belvedere Ave.		3. DATE PRONOUNCED DEAD Month Day Year Hour 9 10 1972 4:15 p.m.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2748	
6. SEX male	7. RACE white	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 10-26-40		10. AGE (In years last birthday) 38	11. BIRTHPLACE (State or foreign country) D.C.		12. CITIZEN OF U.S.A.
13. FATHER'S NAME JOE IRVIN LONG		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Upholsterer		15. MOTHER'S MAIDEN NAME EDNA BUTT	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 213366174		18. INFORMANT EDNA BURNS 1321 M St N.W. WASH D.C.	
19. E 9801.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Overdose of barbiturates and alcohol		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1238 E. Belvedere Avenue	
22D. TIME OF INJURY (APPROX.) 8-?-72 ? m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Ingested barbiturates and alcohol	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE: Russell S. Fisher, M.D. DATE SIGNED: 9-11-72 EXAMINER'S NAME (Type)					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-14-72		24C. NAME OF CEMETERY or CREMATORY Oakland	
24D. LOCATION (City, town, or county) (State) Balto. Ch. Md.		25A. DATE REC'D BY HEALTH DEPT. SEP 27 1972		25B. NAME OF REGISTRAR D. J. H. H. H.	
25C. FUNERAL DIRECTOR 2525 Fleet St 21248		25D. ADDRESS			

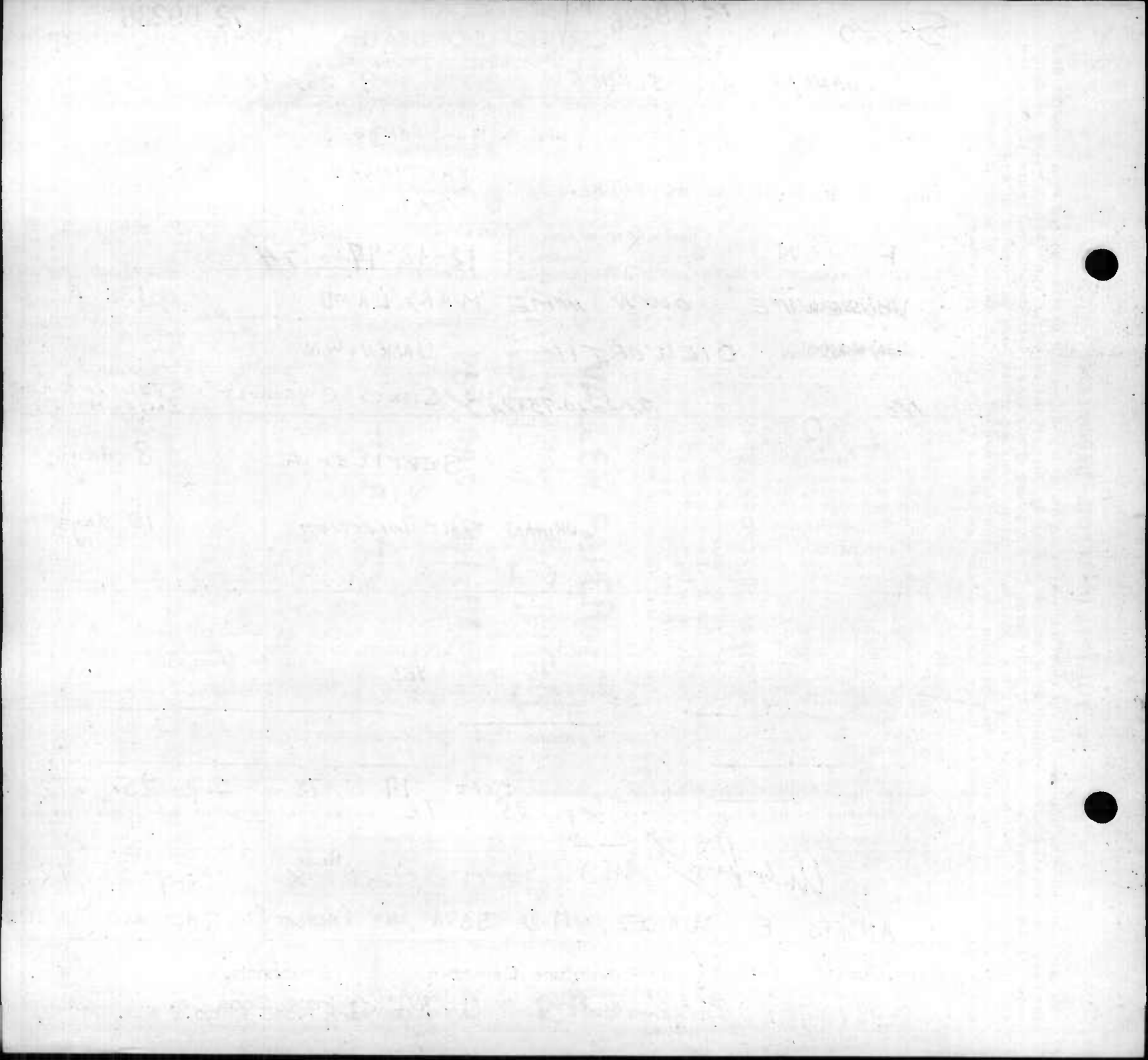
10-13-1972 - Completion of cause of death on a pending medical examiner death certificate-  
Russell S. Fisher, M.D. HS



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
72 09236									
REG. NO. 72 09236									
STATE OF MARYLAND-DEME									
BIRTH NO. 5-430					12 09236				
1. NAME OF DECEASED (Type or Print) HANNAH G. SCHULT					2. DATE AND HOUR OF DEATH 9-25-72 5 p.m.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE UNION MEMORIAL HOSPITAL					A. STATE MARYLAND B. COUNTY 2711				
C. CITY OR TOWN BALTIMORE					D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
E. STREET AND NUMBER 4720 YORK ROAD.									
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-18-97	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME DILWORTH			14. MOTHER'S MAIDEN NAME UNKNOWN						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 212-10-9387		17. INFORMANT MR. SIDNEY C. SCHULT		ADDRESS 4720 York Road BALTO, MD. 21212		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES			(A) IMMEDIATE CAUSE SEPTICEMIA DUE TO, OR AS A CONSEQUENCE OF:				8 days		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) URINARY TRACT INFECTION DUE TO, OR AS A CONSEQUENCE OF:				10 days		
(C)									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from SEPT. 19 1972 to Sep. 25 1972, that (I) (we) lost saw the deceased alive on Sep. 25 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Andres E. Suarez, M.D.			Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> House Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Sep. 25, 72.				
23C. PHYSICIAN'S NAME (Type) ANDRES E. SUAREZ, M.D.			23D. ADDRESS 33rd AND CALVERT ST. BALTIMORE MD. 21218						
24A. BURIAL CREMATION, REMOVAL (Specify) Rem. Burial		24B. DATE 9-29-72		24C. NAME OF CEMETERY OR CREMATORY Bonaventure Cemetery		24D. LOCATION (City, town, or county) Savannah, Ga.			
25A. DATE REC'D BY HEALTH DEPT. SEP 27 1972			25B. NAME OF REGISTRAR Sidney W. Horton		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. 4908 York Road Balto., Md. 21212		ADDRESS		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09237		REG. NO. 72 09237	
BIRTH NO. S-315				72 09237			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
MARGARET STEPHNEY				6:00PM 9/26/72			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
Johns Hopkins Hospital				Md. &			
5. SEX				6. DATE OF BIRTH			
FEMALE				Oct 1, 1908			
7. RACE				9. AGE (In years last birthday)			
NEGRO				63			
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				DOMESTIC			
9. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
PRIVATE FAMILY				London County, Va.			
12. CITIZEN OF WHAT COUNTRY?				USA			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
HENRY BEANER				NELLIE GRAY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
NO				229 26 8222			
17. INFORMANT				ADDRESS			
Son, Husband				Some			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				30 min			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				Cardiac - Respiratory Arrest			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Presumably MI			
(C)							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
Yes				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (APPROX.)			
21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?			
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from 8/20 19 72 to 9/26 19 72				that (I) (we) last saw the deceased alive on 5:50 PM 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE				23B. DATE SIGNED			
Bruce Steckmiller				9/26/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
DR. BRUCE STECKMILLER				Apt 1006 550 N. BROADWAY BALTIMORE			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE			
BURIAL				9/30/72			
24C. NAME OF CEMETERY OR CREMATORY				24D. LOCATION (City, town, or county) (State)			
ARBUTUS MEMORIAL PARK				BALTIMORE MD.			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR			
SEP 28 1972				Lewis T Gwynn			
25C. FUNERAL DIRECTOR				ADDRESS			
LEWIS T GWYNN				4517 PARK HEIGHTS AVE.			

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-322		72 09238		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09238	
BIRTH NO.				STATE OF MARYLAND-DHMH			
1. NAME OF DECEASED (Type or Print) <b>HITCHCOCK, Claude E</b>				2. DATE AND HOUR OF DEATH <b>9-26-72</b> <b>2:00 p.m.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1504</b>			
5. SEX <b>Male</b>				6. RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>part mtr part co</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>part co</b>		8. DATE OF BIRTH <b>8-30-22</b>		9. AGE (In years last birthday) <b>50</b>	
11. BIRTHPLACE (State or foreign country) <b>Balt</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>CLAUDE HITCHCOCK</b>			
14. MOTHER'S MAIDEN NAME <b>Lena Peters</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes World War II</b>		16. SOCIAL SECURITY NO. <b>213-20-7672</b>		17. INFORMANT <b>VA Hospital Records</b> <b>Baltimore, Maryland 21218</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Hepatic Failure with Hepatorenal Syndrome</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Several Months</b>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Cirrhosis of the Liver</b>				(B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>September 16, 1972</b> to <b>September 26, 1972</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>September 26, 1972</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (not) view the body after death.							
23A. SIGNATURE <b>Lawrence A. Fleming MD</b>				23B. DATE SIGNED <b>9-27-72</b>		23C. PHYSICIAN'S NAME (Type) <b>LAWRENCE A. FLEMING MD</b>	
23D. ADDRESS <b>3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>9/30/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>md not ce</b>		24D. LOCATION (City, town, or county) (State) <b>md</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>Sidney Whitson</b>		25C. FUNERAL DIRECTOR <b>Joseph E. Ruse</b>		25D. ADDRESS <b>2222-24 N. York Ave</b>	

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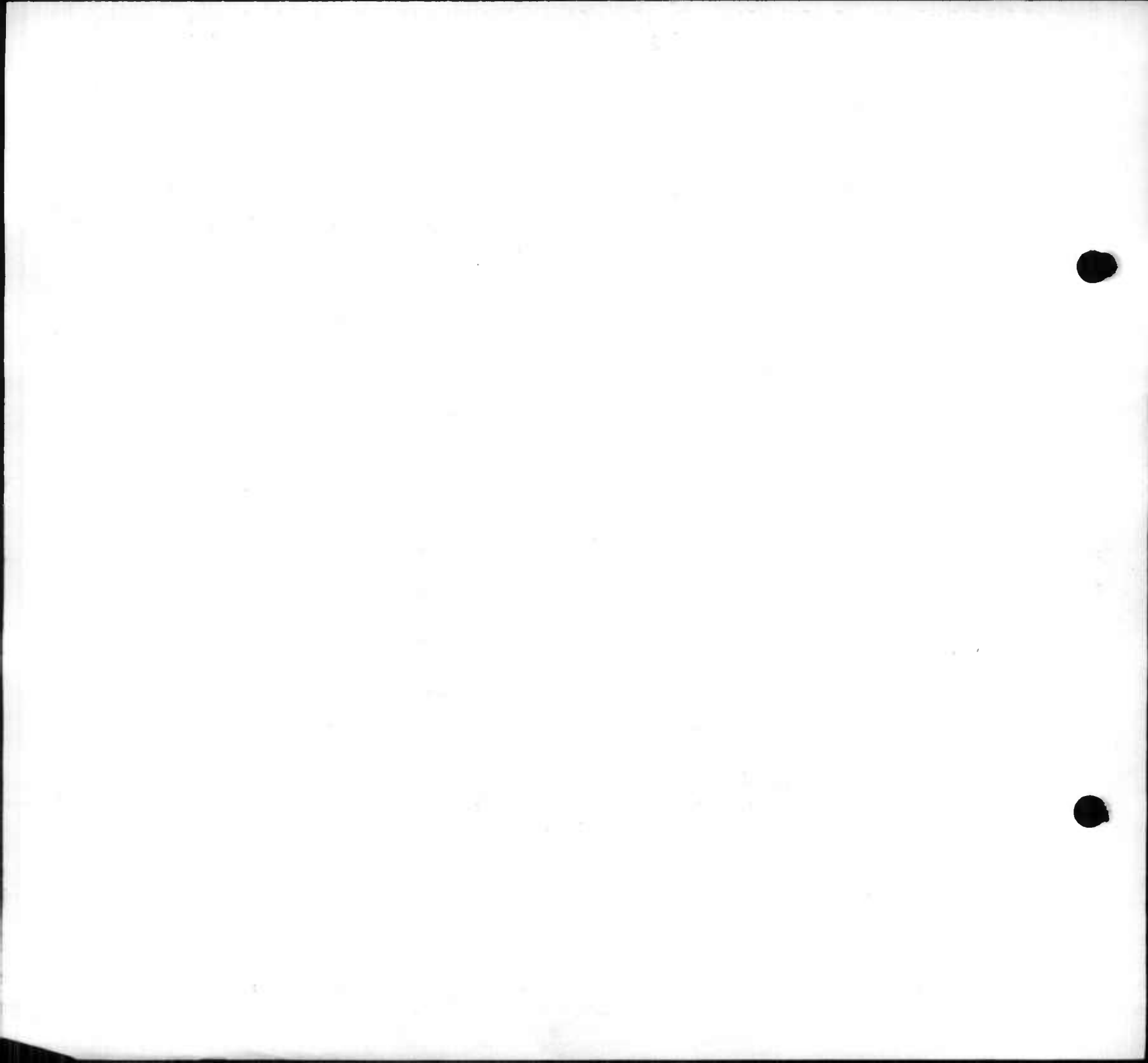


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-530		72 09239		BALTIMORE CITY HEALTH DEPARTMENT		72 09239	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>SMITH Raymond Jr</i>				2. DATE AND HOUR OF DEATH <i>9/26/72 6:30 A.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>University Hospital 38</i>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1703</i>			
				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>1056 Pennsylvania Ave. Baltimore</i>			
5. SEX <i>MALE</i>	6. RACE <i>NEGRO</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>8-6-27</i>	9. AGE (In years last birthday) <i>45</i>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME <i>Raymond Smith Sr</i>			
14. MOTHER'S MAIDEN NAME				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <i>Chart</i>			
18. <i>303.9 I</i> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Acidosis</i>		<i>2 1/2 wks</i>	
				(B) <i>Chronic Renal Failure</i> DUE TO, OR AS A CONSEQUENCE OF: <i>Alcoholism</i>		<i>6-12 wks</i>	
				(C) <i>Alcoholism</i>		<i>20 yrs</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Alcoholism</i>							
19A. DATE OF OPERATION <i>2 NA</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>NA</i>		20A. AUTOPSY? (Yes or No) <i>YES</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>NA</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>NA</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>NA</i>		21C. WHERE DID INJURY OCCUR? <i>NA</i>		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) <i>NA</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>NA</i>			
22. I certify that (I) (this hospital) attended the deceased from <i>9/26</i> 19 <i>72</i> and that (I) (we) lost saw the deceased alive on <i>9/26</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Ronald E. Kelly</i>				23B. DATE SIGNED <i>9/26/72</i>		23C. PHYSICIAN'S NAME (Type) <i>DEGREE</i>	
23D. ADDRESS <i>DEGREE</i>				23E. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9/30/72</i>		24C. NAME OF CEMETERY or CREMATORY <i>MT Auburn Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md</i>	
25A. DATE RECD BY HEALTH DEPT. <i>SEP 28 1972</i>		25B. NAME OF REGISTRAR <i>Adolphus Halstead</i>		25C. FUNERAL DIRECTOR <i>Adolphus Halstead</i>		25D. ADDRESS <i>1206 W North Ave</i>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09240
CERTIFICATE OF DEATH				REG. NO.
STATE OF MARYLAND - DEPT. OF HEALTH				11:10 P.M.
BIRTH NO. <b>N-250</b>		72 09240		
1. NAME OF DECEASED <b>NEWSOME, ANNA</b>		2. DATE AND HOUR OF DEATH <b>9/26/72</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>MARYLAND GENERAL HOSP.</b>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALT</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>MARYLAND GENERAL HOSP.</b>		C. CITY OR TOWN <b>BALTIMORE</b>		
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		E. STREET AND NUMBER <b>457 OXFORD CT</b>		
5. SEX <b>F</b>	6. RACE <b>BLACK</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>?</b>	9. AGE (In years last birthday) <b>71</b>
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>N. CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>DAVID HILL</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>212-12-1556</b>		17. INFORMANT <b>EVA MORRIS</b> ADDRESS <b>550 GOLD ST BALTIMORE MD.</b>
18. <b>43610 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CVA</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>HYPERTENSION</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 MO.</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>7/24</b> 19 <b>72</b> to <b>9/26</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>9/26</b> 19 <b>72</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Kleeman</b>		23B. DATE SIGNED <b>9/26/72</b>		23C. PHYSICIAN'S NAME (Type) <b>J. KLEEMAN</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/29/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt Auburn Cemetery</b>
24D. LOCATION <b>Baltimore Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 28 1972</b>		
25B. NAME OF REGISTRAR <b>Adolphus Halstead</b>		25C. FUNERAL DIRECTOR <b>Adolphus Halstead</b> ADDRESS <b>1206 W North Ave</b>		

10/11/72 - Correction form from funeral director.

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09241
72 09241 CERTIFICATE OF DEATH				STATE OF MARYLAND - DHMH
BIRTH NO. Y-000		1. NAME OF DECEASED (Type or Print) <b>Yu Fuk Chun</b> <b>FUK CHUN YU/Fok Chun Yee</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <b>9/25/72 4:00 PM</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>108 South Clinton Street</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>BRAZIL</b> B. COUNTY <b>V54</b>		
5. SEX <b>Male</b>		6. RACE <b>White</b>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 3, 1915</b>		
9. AGE (In years last birthday) <b>57</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>OWNER</b>		
11. BIRTHPLACE (State or foreign country) <b>Canton, CHINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>Brazil - ?</b>		
13. FATHER'S NAME <b>Yat Lei Yu</b>		14. MOTHER'S MAIDEN NAME <b>Sheung Ngor Chin</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		
17. INFORMANT: <b>son-in-law</b>		ADDRESS <b>Gom Moon Tom, 108 S. Clinton St., City.</b>		
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Cardiorespiratory arrest</b>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Disseminated malignancy</b>				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>prob. pancreatic origin</b>				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>9/14</b> 19 <b>72</b> to <b>9/16</b> 19 <b>72</b> . that (I) (we) last saw the deceased alive on <b>9/16</b> 19 <b>72</b> and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Martha S. Koppen MD</b>				23B. DATE SIGNED <b>9/26/72</b>
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <b>Johns Hopkins Hospital</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>9/27/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>LORRAINE CEMETERY</b>
24D. LOCATION (City, town, or county) (State) <b>WOODLAWN, BALTO.CO., MD.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 28 1972</b>		
25B. NAME OF REGISTRAR <b>Stewart &amp; Mowen</b>		25C. FUNERAL DIRECTOR ADDRESS <b>STEWART &amp; MOWEN CO. 108 W. North Av. City</b>		

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72 09242

STATE OF MARYLAND-DEME  
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 09242

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>VIRGINIA MARTIN</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 3026 Guilford Ave.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>9 19 1972 5:10 p M.</b>	
6. SEX <b>female</b>		7. RACE <b>white</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>5/12/94</b>		10. AGE (In years lost birthday) <b>75</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>VA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1202</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. <b>212-12-859</b>		18. INFORMANT <b>Mr. B. Martin</b>	
19. <b>767.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>Dehydration and sepsis</b> CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>multiple decubitus ulcers complicating a simple fall and senility</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes</b>		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>R. Fisher</b> M.D. EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b> DATE SIGNED <b>9-20-72</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>CREMATION</b>		24B. DATE <b>SEP 22 72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>WOODLAWN PARK</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 28 1972</b>		25B. NAME OF REGISTRAR <b>A. J. H. H. H.</b>	
25C. FUNERAL DIRECTOR <b>SAUL T. BREDD</b>		ADDRESS <b>3401 GRANTLEY</b>	

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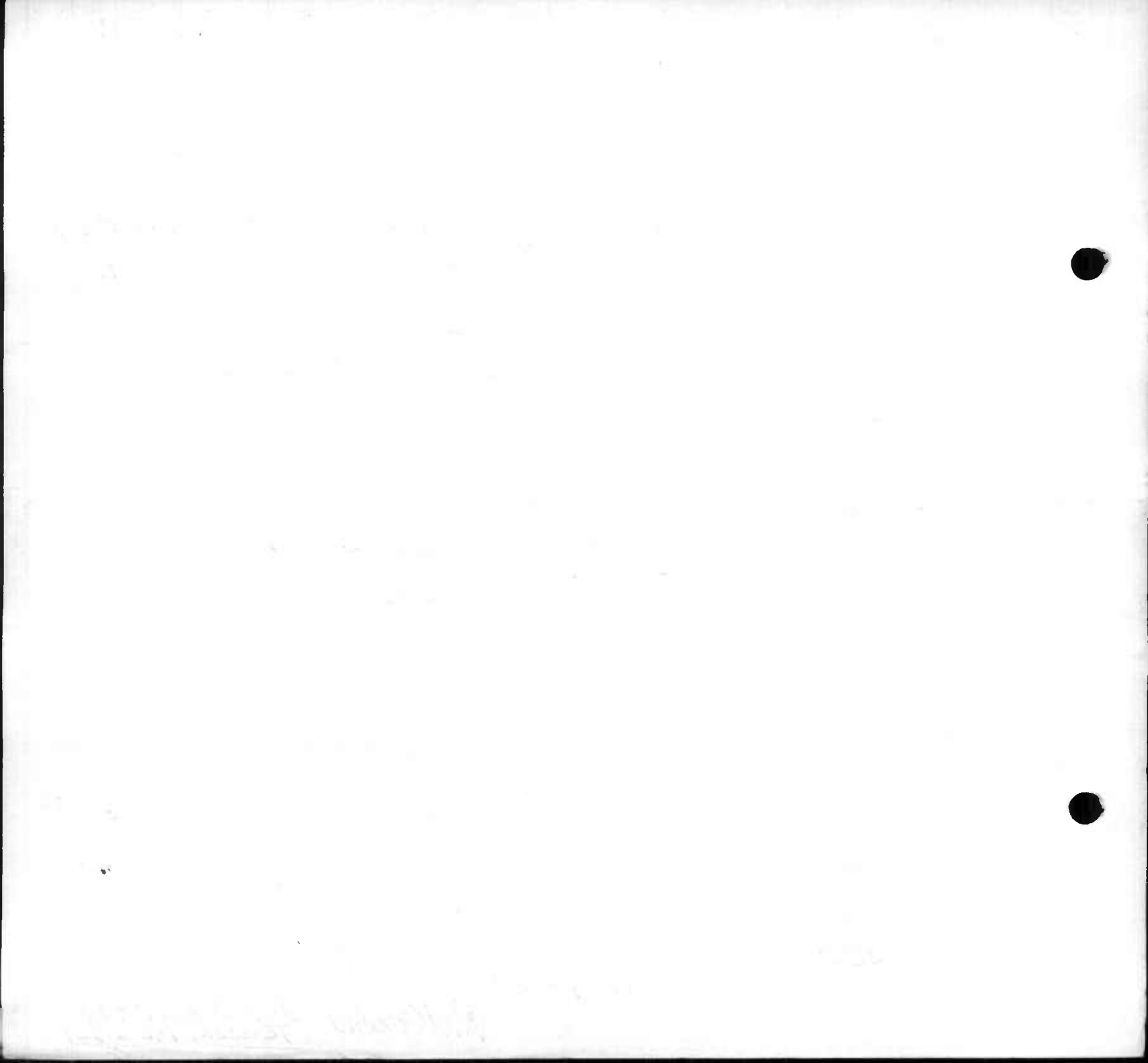
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09243 4	
CERTIFICATE OF DEATH				REG. NO. 72 09243 4	
BIRTH NO. 72-1400372 09243				STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print) Baby boy Sorrell		2. DATE AND HOUR OF DEATH 9/22/72 1 a.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Univ of Maryland		A. STATE 841 Whitelock St Apt 7 #17			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN Baltimore Md		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 841 WHITELOCK ST. APT #17			
5. SEX M	6. RACE N.W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-22-72	9. AGE (In years last birthday)	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Barbara Sorrell			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO.		17. INFORMANT R. TAKLA MD	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Lung immaturity		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Severe Prematurity			
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/22 1972 to 9/22 1972 that (I) (we) last saw the deceased alive on 9/22 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE R. Takla		23B. DATE SIGNED 9/22/72		23C. PHYSICIAN'S NAME (Type) ROGER TAKLA	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 9-25-72		24C. NAME OF CEMETERY or CREMATORY Univ. of MD Hospy. Dept. Ped.	
25A. DATE REC'D BY HEALTH DEPT. SEP 28 1972		25B. NAME OF REGISTRAR Sidney Whitton		25C. FUNERAL DIRECTOR R. J. Curran	
				25D. ADDRESS 817 SCARLETT TOWSON, MD 21204	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

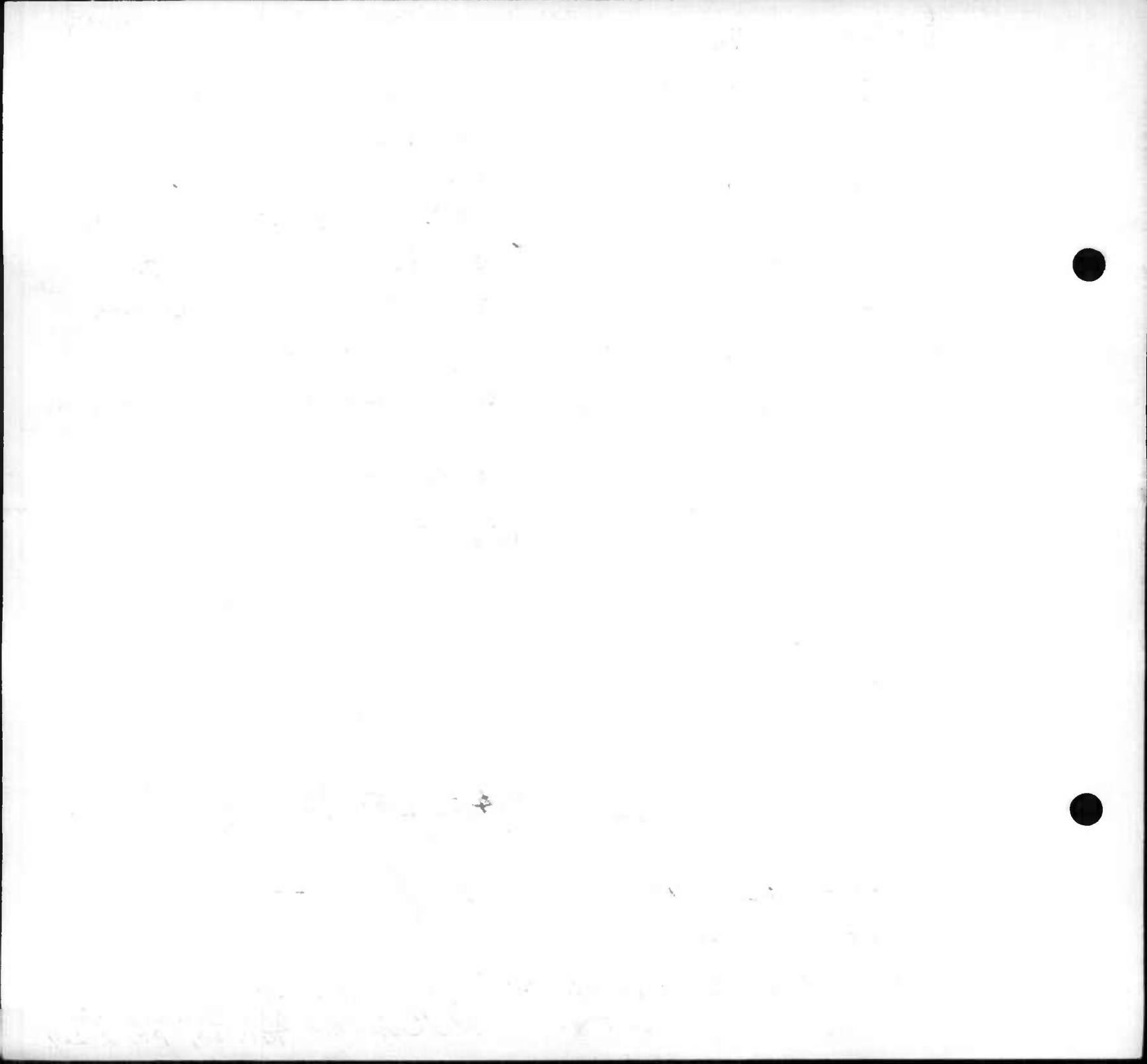
BALTIMORE CITY HEALTH DEPARTMENT 72 09244 CERTIFICATE OF DEATH				REG. NO. 72 09244 STATE OF MARYLAND	
BIRTH NO. <u>72-13207</u>		1. NAME OF DECEASED (Type or Print) <u>BABY BOY RICHARDSON</u>		2. DATE AND HOUR OF DEATH <u>9/6/72</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNIVERSITY OF MARYLAND HOSPITAL GREENE ST.</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Balt City</u>		
			C. CITY OR TOWN <u>Balt</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>1101 Orleans St Apt 543</u>		
5. SEX <u>MALE</u>	6. RACE <u>BLACK</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/6/72</u>	9. AGE (In years last birthday)	If Under 1 Mo. <input type="checkbox"/> If Under 1 Yr. <input type="checkbox"/> If Under 24 Hrs. <input type="checkbox"/> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>EDDIE MACK</u>			14. MOTHER'S MAIDEN NAME <u>JOANN RICHARDSON</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <u>776.2 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenic, etc. It means the disease, injury or complication which caused death.) <u>Lung immaturity</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Severe prematurity</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Severe prematurity</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>one hour</u>
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9/6/72</u> 19 <u>72</u> to <u>9/6</u> 19 <u>72</u> that (I) (we) lost saw the deceased alive on <u>9/6</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>R. TAKLA</u>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>ROBERT TAKLA MD - Pediatric</u>				23D. ADDRESS <u>Univ. of Md. Dept. of Pediatrics</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>9-25-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>U of M Anatomy Board</u>	
				24D. LOCATION (City, town, or county) (State) <u>Balt. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 28 1972</u>		25B. NAME OF REGISTRAR <u>Andrew Johnson</u>		25C. FUNERAL DIRECTOR <u>R. J. CURRAN</u>	
				ADDRESS <u>817 SCARLEN DR TOWSON, MD 21204</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09245
BIRTH NO. 72-13434 72 09245				REG. NO. 72 09245
1. NAME OF DECEASED (Type or Print) <u>Smith, Baby boy</u>				STATE OF MARYLAND-DEME
2. DATE AND HOUR OF DEATH <u>Sept. 5, 1972 5:26 pm</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2001</u>		5. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>University of Maryland Hospital</u> <u>38</u>		
6. C. CITY OR TOWN <u>Baltimore</u>		7. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
8. E. STREET AND NUMBER <u>19 N. Monroest. Balto. Md 21216</u>				
9. SEX <u>Male</u>	10. RACE <u>Black</u>	11. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12. DATE OF BIRTH <u>9-3-72</u>	13. AGE (In years last birthday) <u>2</u>
14. 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>		15. 10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>		16. 11. BIRTHPLACE (State or foreign country) <u>Bonsecours Hosp. Baltimore</u>
17. 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		18. 13. FATHER'S NAME <u>Richard Watkins</u>		
19. 14. MOTHER'S MAIDEN NAME <u>Helen Smith</u>		20. 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
21. 16. SOCIAL SECURITY NO. <u>-</u>		22. 17. INFORMANT <u>Roger TAKLA</u>		
23. ADDRESS <u>Univ. of Md Hospital</u>				
24. 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Respiratory arrest</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Prematurity</u>				25. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2</u>
26. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
27. 19A. DATE OF OPERATION <u>0</u>		28. 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-</u>		29. 20A. AUTOPSY? (Yes or No) <u>No</u>
30. 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		31. 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		
32. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		33. 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
34. 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) <u>9/5/72 5:26 pm</u>		35. 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
36. 21F. HOW DID INJURY OCCUR?				
37. 22. I certify that (I) (this hospital) attended the deceased from <u>9/4/72 12 am</u> to <u>9/5/72 5:26 pm</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>9/5/72 5:26 pm</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
38. 23A. SIGNATURE <u>R. Takla</u>		39. 23B. DATE SIGNED <u>9/5/72</u>		40. 23C. PHYSICIAN'S NAME (Type) <u>ROGER Y. TAKLA</u>
41. 23D. ADDRESS <u>Univ. of Md Hosp. Dept of Pediatrics</u>		42. 24A. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		
43. 24B. DATE <u>9-25-72</u>		44. 24C. NAME OF CEMETERY or CREMATORY <u>C.O.A.M. ANATOMY BLDG. BAL MD</u>		45. 24D. LOCATION (City, town, or county) (State) <u>BAL MD</u>
46. 25A. DATE REC'D BY HEALTH DEPT <u>SEP 28 1972</u>		47. 25B. NAME OF REGISTRAR <u>Andrew Johnson</u>		48. 25C. FUNERAL DIRECTOR <u>RO CURRAN</u>
49. ADDRESS <u>817 S. CARLETON</u>		50. ADDRESS <u>7020 N. MONTGOMERY AVE. BAL MD 21204</u>		

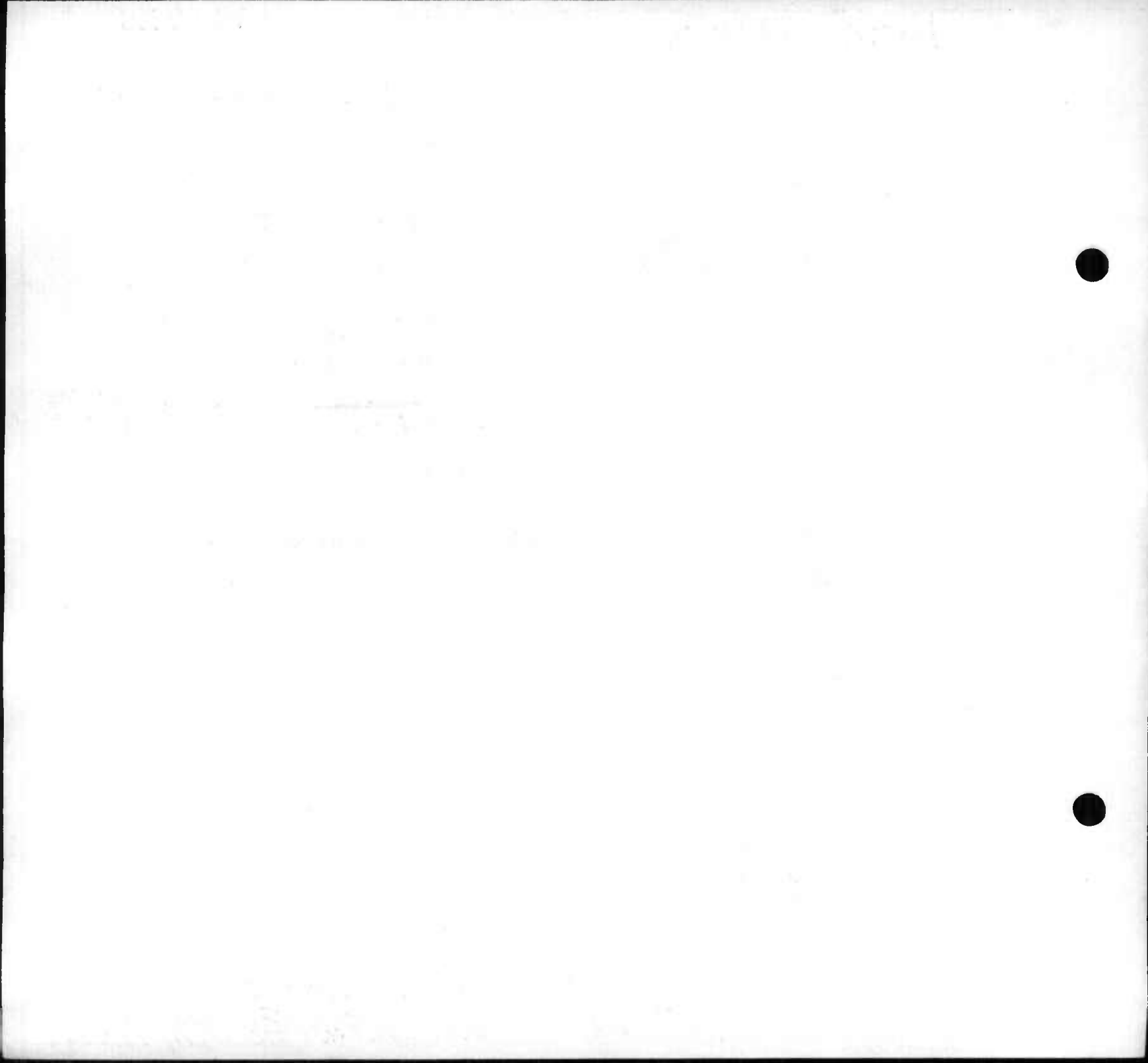


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-520 72 09246		BALTIMORE CITY HEALTH DEPARTMENT		72 09246	
BIRTH NO.		CERTIFICATE OF DEATH		STATE OF MARYLAND - DEPT	
1. NAME OF DECEASED (Type or Print)		LUCIUS JONES		2. DATE AND HOUR OF DEATH 9/20/72 4:30p 4-45p M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE M.D. B. COUNTY BALTO		5. CITY OR TOWN BAITIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION Church Home & Hospital 35		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M.		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 5.20.05		9. AGE (in years last birthday) 67		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
11. BIRTHPLACE (State or foreign country) G.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Oliver Jones	
14. MOTHER'S MAIDEN NAME Jesse Evans		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Dr. H. Matlock MICK MAYROS SAMP		ADDRESS Chesapeake & Hospital Baltimore, Maryland		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. 492X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Cardiac Arrest and stroke DUE TO, OR AS A CONSEQUENCE OF: Cerebral damage (B) Emphysema, left pneumonia many years DUE TO, OR AS A CONSEQUENCE OF: (C) Post op. Exsiccation of abd wound, 91 weeks repaired Post bulbar ulcer (operation) 2 yr.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		19A. DATE OF OPERATION Aug 23 1972		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Post bulbar ulcer.	
20A. AUTOPSY? (Yes or No) Yes.		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH Notified medical examiner		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8.20 1972 to 9.20 1972 that (I) (we) last saw the deceased alive on 9.20 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Hani Matlock		23B. DATE SIGNED 9.20 1972		23C. PHYSICIAN'S NAME (Type) Hani Matlock	
24A. BURIAL - CREMATION, REMOVAL (Specify)		24B. DATE 9.26.72		24C. NAME OF CEMETERY or CREMATORY Carm. Anthony Boro	
24D. LOCATION (City, town, or county) (State) BALT. MD		24E. ADDRESS Church Home & Hospital		24F. FUNERAL DIRECTOR R.J. CURRAN	
25A. DATE REC'D BY HEALTH DEPT. SEP 28 1972		25B. NAME OF REGISTRAR Sidney Johnston		25C. ADDRESS 517 SCARLE RD TOWSON MD 21204	

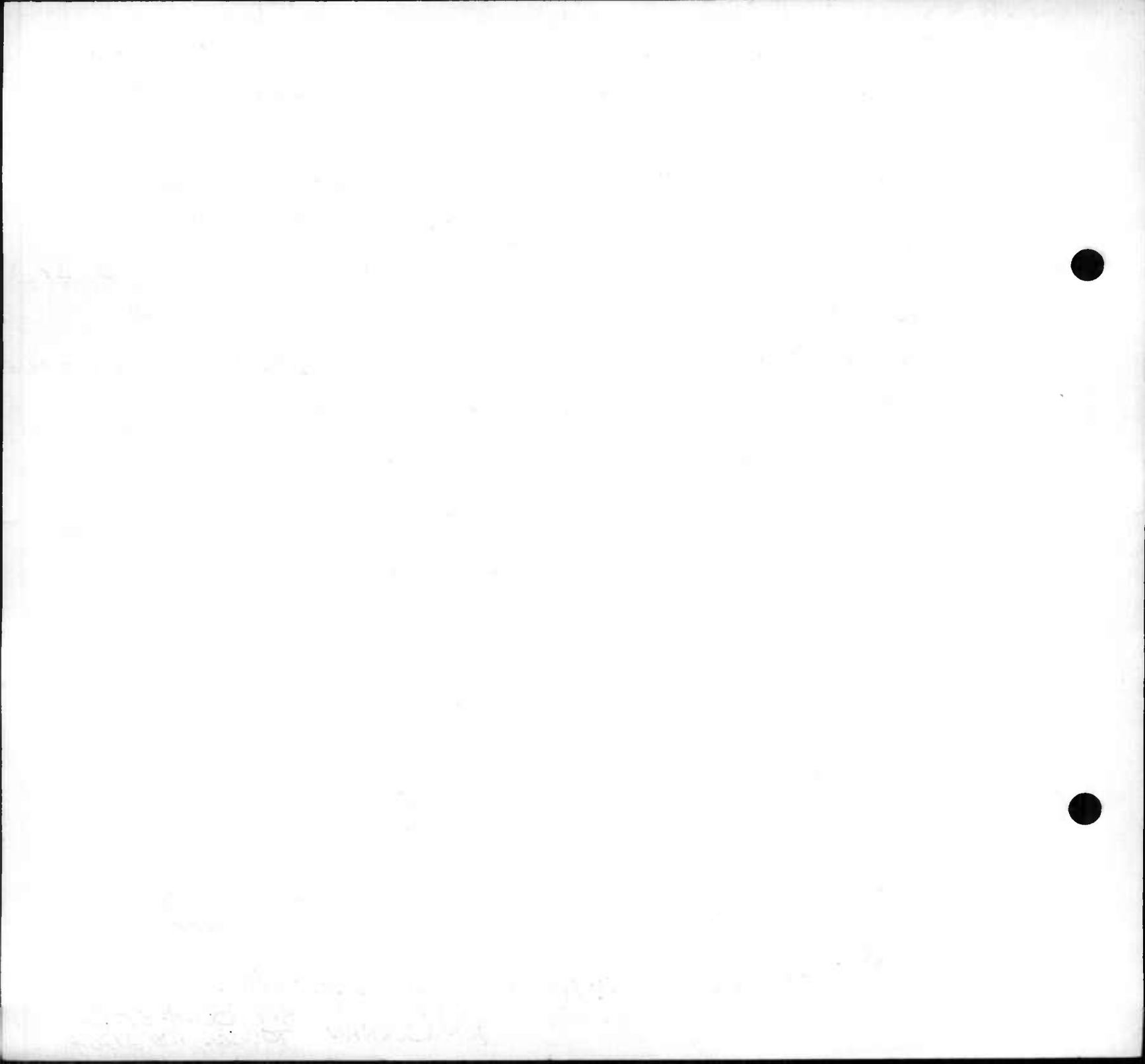




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

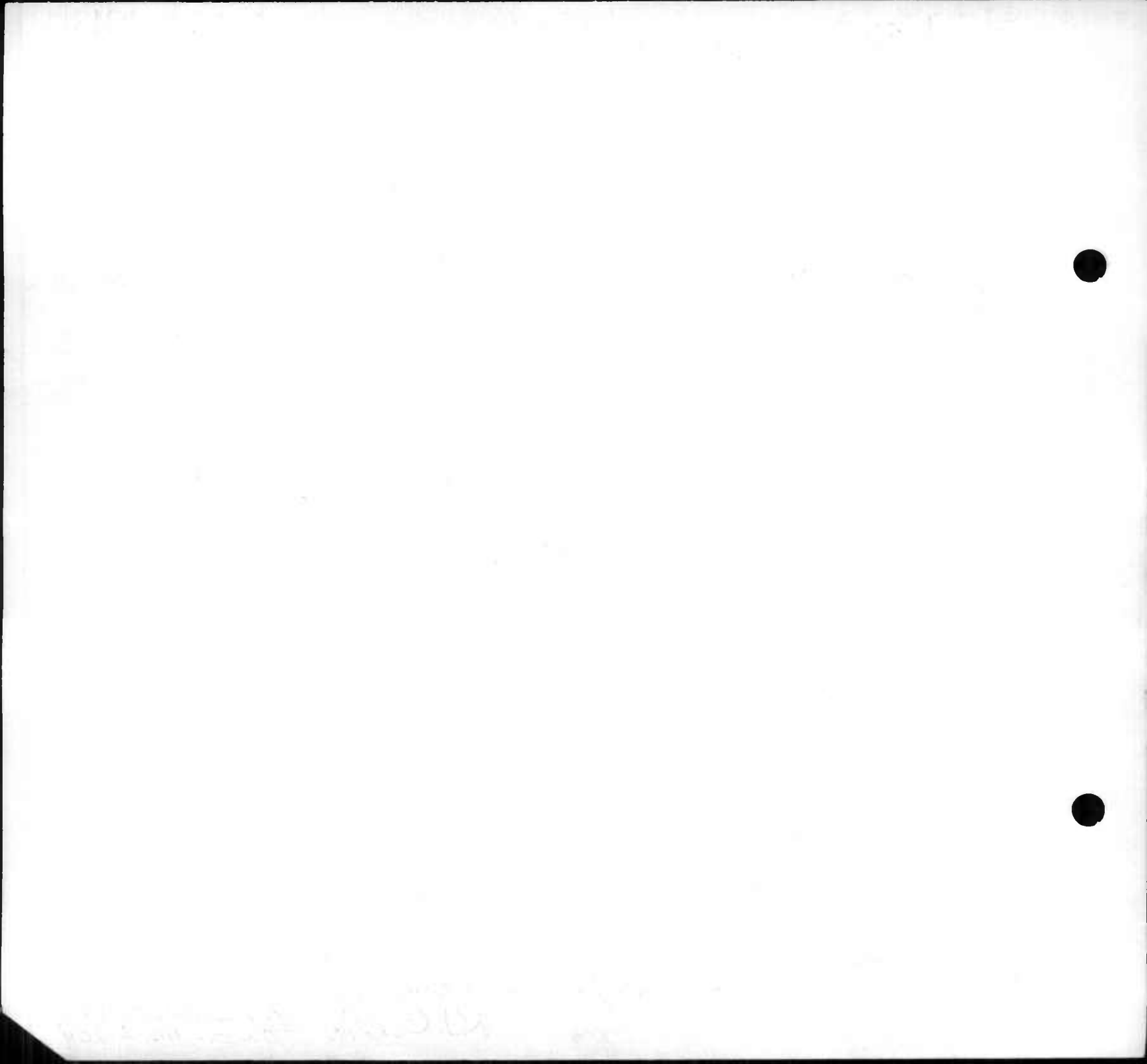
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09247	
G-560 72 09247				STATE OF MARYLAND - DEMO	
BIRTH NO. 72-13564		CERTIFICATE OF DEATH		DATE AND HOUR OF DEATH 9/16/72 8:55 A.M.	
1. NAME OF DECEASED (Type or Print) <b>BABY GIRL GAUMER</b>		2. DATE AND HOUR OF DEATH			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>UNIVERSITY HOSPITAL 38</b>		A. STATE <b>MD</b>		B. COUNTY <b>21211 1207</b>	
		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>2930 REMINGTON AVE</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/16/72</b>	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: Hours: Min. <b>3 34</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NEW BORN</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>UNKNOWN</b>			
14. MOTHER'S MAIDEN NAME <b>MILDRED GAUMER SAME AS ABOVE</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT ADDRESS <b>HOSPITAL RECORD</b>			
18. <b>7769 I</b> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>ATELECTASIS</b>		<b>3 1/2 hr</b>			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>NEONATAL APNEA</b>			
ANTECEDENT CAUSES		<b>3 1/2 hr</b>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>PREMATURITY</b>			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>NONE</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>No</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/16</b> 19__ to __ 19__ that (I) (we) last saw the deceased alive on <b>9/16</b> 19__ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>K. N. SIVASUBRAMANIAN M.D.</b>				23B. DATE SIGNED <b>9/16/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>K. N. SIVASUBRAMANIAN M.D.</b>		23D. ADDRESS <b>UNIVERSITY HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>9-25-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Worm Anatomy Board</b>	
24D. LOCATION (City, town, or county) <b>BALT. MD.</b>		24E. LOCATION (State) <b>BALT. MD.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 28 1972</b>		25B. NAME OF REGISTRAR <b>James H. ...</b>		25C. FUNERAL DIRECTOR <b>R. J. CURRAN 817 SCARLETT DR. TOWSON, MD 21204</b>	



# FUNERAL DIRECTOR: IMPORTANT

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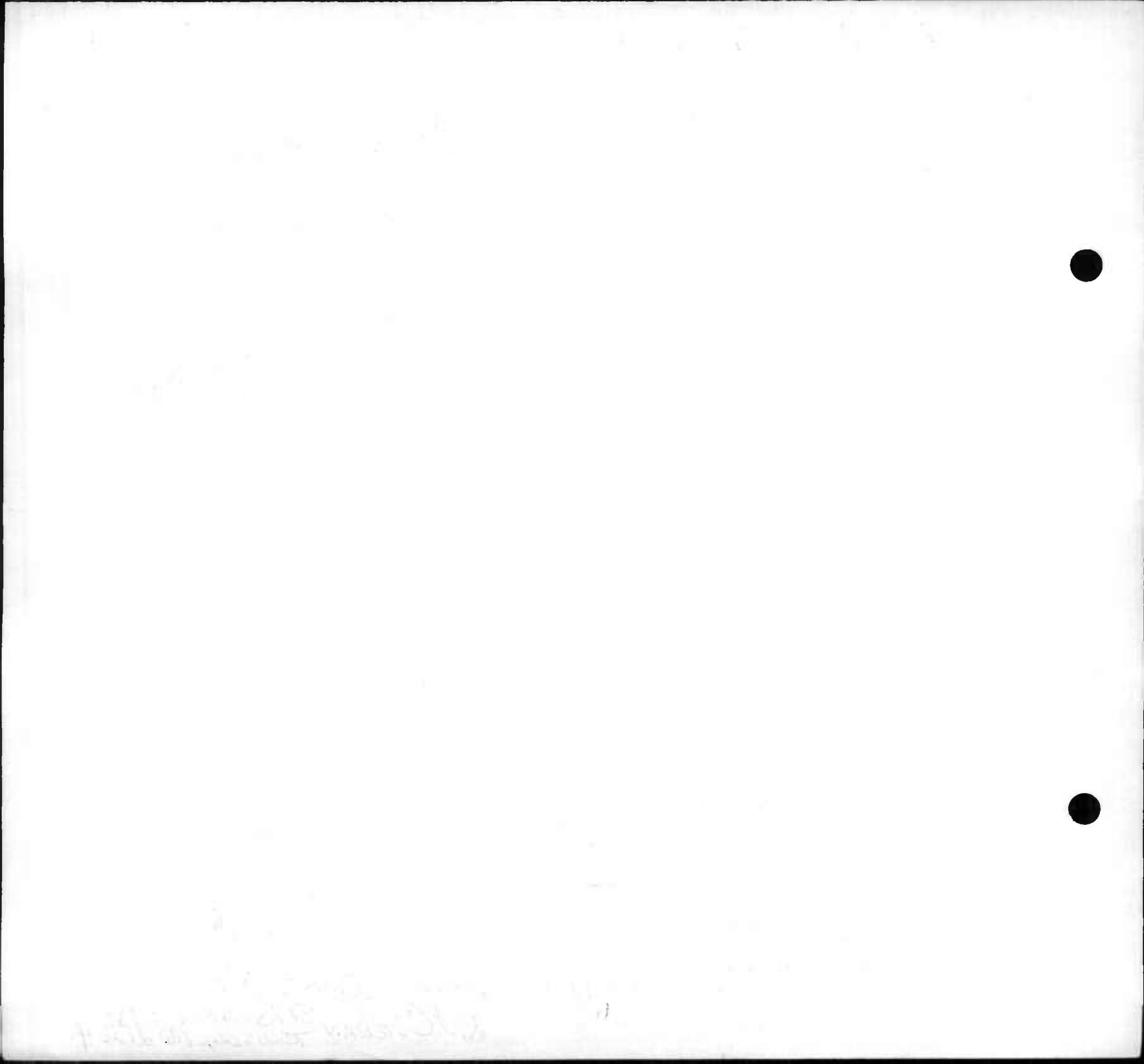
BALTIMORE CITY HEALTH DEPARTMENT				72 09248	
J-525				REG. NO.	
BIRTH NO. 72-14116 72 09248				STATE OF MARYLAND-DEMD	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH	
Johnson, Baby Boy				9/16/72 11:08 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
University Hospital of Md.				BORN Union Memorial Hospital	
38				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
Baltimore, Md.				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER				F. INSIDE CITY LIMITS?	
1821 Chilton Street				906	
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	
M		B		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
New born				9/16/72	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		9. AGE (In years last birthday)	
		Roberta Johnson		12 15	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country)	
NO		NONE		Union Memorial Hosp, Balt., Md.	
17. INFORMANT		ADDRESS		12. CITIZEN OF WHAT COUNTRY?	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES				Hyline Membrane Disease	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Prematurity	
(C) _____				DUE TO, OR AS A CONSEQUENCE OF:	
II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
None				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 9/16/72 19 to 9/16/72 19 that (I) (we) last saw the deceased alive on 9/16/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
J. Y. Eaton, M.D.				9/16/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
F. Y. EATON, M.D.				University of Md Hospital	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
9-25-72		24D. LOCATION (City, town, or county) (State)		24E. NAME of CEMETERY or CREMATORY	
SEP 28 1972		24F. NAME of CEMETERY or CREMATORY		24G. NAME of CEMETERY or CREMATORY	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
25D. NAME OF REGISTRAR		25E. NAME OF REGISTRAR		25F. NAME OF REGISTRAR	
25G. NAME OF REGISTRAR		25H. NAME OF REGISTRAR		25I. NAME OF REGISTRAR	
25J. NAME OF REGISTRAR		25K. NAME OF REGISTRAR		25L. NAME OF REGISTRAR	
25M. NAME OF REGISTRAR		25N. NAME OF REGISTRAR		25O. NAME OF REGISTRAR	
25P. NAME OF REGISTRAR		25Q. NAME OF REGISTRAR		25R. NAME OF REGISTRAR	
25S. NAME OF REGISTRAR		25T. NAME OF REGISTRAR		25U. NAME OF REGISTRAR	
25V. NAME OF REGISTRAR		25W. NAME OF REGISTRAR		25X. NAME OF REGISTRAR	
25Y. NAME OF REGISTRAR		25Z. NAME OF REGISTRAR		25AA. NAME OF REGISTRAR	
25AB. NAME OF REGISTRAR		25AC. NAME OF REGISTRAR		25AD. NAME OF REGISTRAR	
25AE. NAME OF REGISTRAR		25AF. NAME OF REGISTRAR		25AG. NAME OF REGISTRAR	
25AH. NAME OF REGISTRAR		25AI. NAME OF REGISTRAR		25AJ. NAME OF REGISTRAR	
25AK. NAME OF REGISTRAR		25AL. NAME OF REGISTRAR		25AM. NAME OF REGISTRAR	
25AN. NAME OF REGISTRAR		25AO. NAME OF REGISTRAR		25AP. NAME OF REGISTRAR	
25AQ. NAME OF REGISTRAR		25AR. NAME OF REGISTRAR		25AS. NAME OF REGISTRAR	
25AT. NAME OF REGISTRAR		25AU. NAME OF REGISTRAR		25AV. NAME OF REGISTRAR	
25AW. NAME OF REGISTRAR		25AX. NAME OF REGISTRAR		25AY. NAME OF REGISTRAR	
25AZ. NAME OF REGISTRAR		25BA. NAME OF REGISTRAR		25BB. NAME OF REGISTRAR	
25BC. NAME OF REGISTRAR		25BD. NAME OF REGISTRAR		25BE. NAME OF REGISTRAR	
25BF. NAME OF REGISTRAR		25BG. NAME OF REGISTRAR		25BH. NAME OF REGISTRAR	
25BI. NAME OF REGISTRAR		25BJ. NAME OF REGISTRAR		25BK. NAME OF REGISTRAR	
25BL. NAME OF REGISTRAR		25BM. NAME OF REGISTRAR		25BN. NAME OF REGISTRAR	
25BO. NAME OF REGISTRAR		25BP. NAME OF REGISTRAR		25BQ. NAME OF REGISTRAR	
25BR. NAME OF REGISTRAR		25BS. NAME OF REGISTRAR		25BT. NAME OF REGISTRAR	
25BU. NAME OF REGISTRAR		25BV. NAME OF REGISTRAR		25BW. NAME OF REGISTRAR	
25BX. NAME OF REGISTRAR		25BY. NAME OF REGISTRAR		25BZ. NAME OF REGISTRAR	
25CA. NAME OF REGISTRAR		25CB. NAME OF REGISTRAR		25CC. NAME OF REGISTRAR	
25CD. NAME OF REGISTRAR		25CE. NAME OF REGISTRAR		25CD. NAME OF REGISTRAR	
25CF. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR		25CE. NAME OF REGISTRAR	
25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR		25CF. NAME OF REGISTRAR	
25CI. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CF. NAME OF REGISTRAR	
25CK. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25CL. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25CM. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25CN. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25CO. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25CP. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25CQ. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25CR. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25CS. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25CT. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25CU. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25CV. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25CW. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25CX. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25CY. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25CZ. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25DA. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25DB. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25DC. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25DD. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25DE. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25DF. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25DG. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25DH. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25DI. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25DJ. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25DK. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25DL. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25DM. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25DN. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25DO. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25DP. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25DQ. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25DR. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25DS. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25DT. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25DU. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25DV. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25DW. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25DX. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25DY. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25DZ. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25EA. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25EB. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25EC. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25ED. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25EE. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25EF. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25EG. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25EH. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25EI. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25EJ. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25EK. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25EL. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25EM. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25EN. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25EO. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25EP. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25EQ. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25ER. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25ES. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25ET. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25EU. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25EV. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25EW. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25EX. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25EY. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25EZ. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25FA. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25FB. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25FC. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25FD. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25FE. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25FF. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25FG. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25FH. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25FI. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25FJ. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25FK. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25FL. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25FM. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25FN. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25FO. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25FP. NAME OF REGISTRAR		25CH. NAME OF REGISTRAR		25CG. NAME OF REGISTRAR	
25FQ. NAME OF REGISTRAR					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 09249 4</b>
BIRTH NO. <b>72 09249</b> <b>CERTIFICATE OF DEATH</b>				STATE OF MARYLAND-DMH
1. NAME OF DECEASED (Type as Print) <b>Baby Girl Young</b>		2. DATE AND HOUR OF DEATH <b>9/23/72 12:30 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>University of Maryland Hospital 38</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>521 N. Calhoun St. 1602</b>		
5. SEX <b>F</b>	6. RACE <b>B</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/23/72</b>	9. AGE (in years last birthday) <b>30</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>newborn</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MD</b>
13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>Sandra Young</b>		
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>521 N. Calhoun St</b> ADDRESS
18. <b>777X I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Prematurity</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <b>NONE</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>9/23</b> 19 <b>72</b> to <b>9/23</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>9/23</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>J. Y. Eaton, M.D.</b>		23B. DATE SIGNED <b>9/23/72</b>		23C. PHYSICIAN'S NAME (Type) <b>F. V. EATON</b>
23D. ADDRESS <b>Univ. of Md. Hospital</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>9-25-72</b>		
24B. DATE <b>9-25-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>USCM Anatomy Bldg</b>		24D. LOCATION <b>Bktr. Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 28 1972</b>		25B. NAME OF REGISTRAR <b>Andrey Whitton</b>		25C. FUNERAL DIRECTOR <b>R. J. CURRAN</b> ADDRESS <b>8175 SCARLETT DR. TOWSON, MD 21204</b>

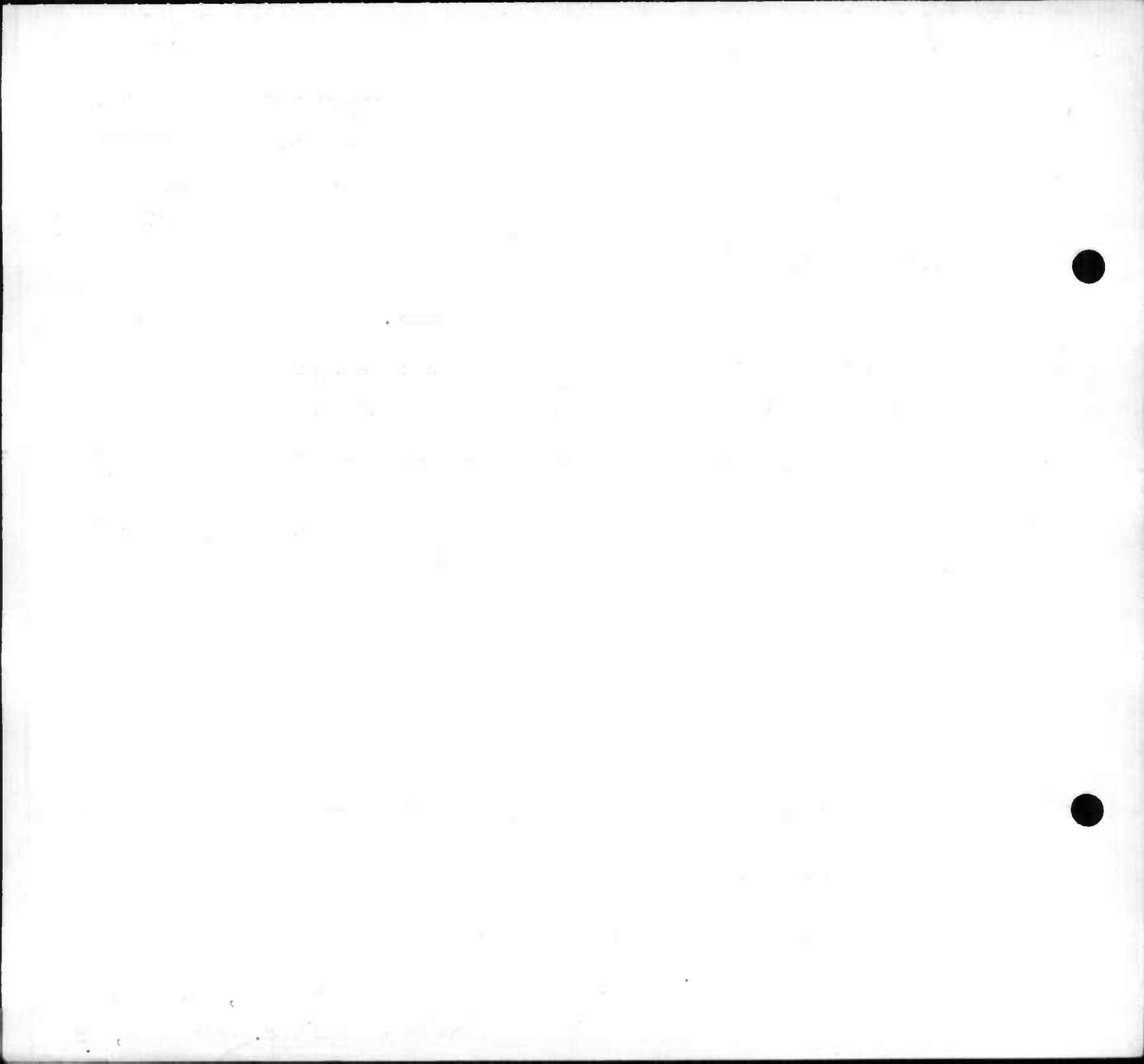




FUNERAL DIRECTOR: IMPORTANT

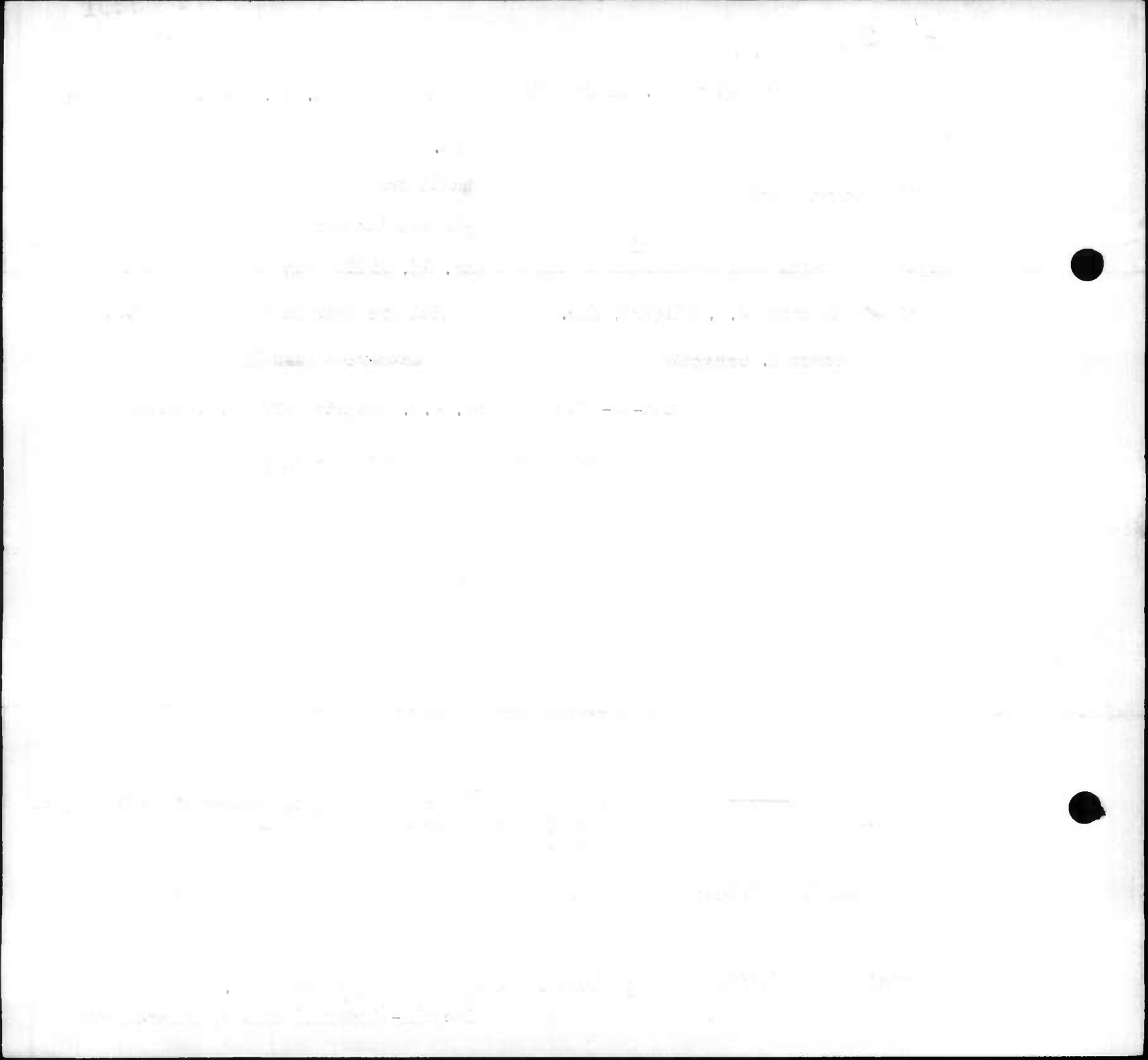
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09250		72 09250	
BIRTH NO. <span style="float: right;">L-360</span>				72 09250		72 09250	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
JOSEPH B. LODER				September 26 12.40 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
UNIVERSITY OF MARYLAND 8 HOSPITAL 22 GREENE ST.				N.Y. <del>ROCHESTER</del> V29			
5. SEX				6. RACE			
Male				White			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				8. DATE OF BIRTH			
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				3/13/98			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)			
PHYSICIAN				Penna.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Anthony Loder				Clara Schmidt			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
Yes WW 1				055-38-3899A			
17. INFORMANT				ADDRESS			
E. R. Chart.							
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				HOURS.			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				624.			
ANTECEDENT CAUSES							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
YES				NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Approx.)			
21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?			
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (1) (this hospital) attended the deceased from 9/25/72, 11.40 to 9/26/72, 0.40 and that (1) (we) lost saw the deceased alive on 9/26/72, 0.40 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
JULIO FREITAS				9/26/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
JULIO FREITAS				UNIV. MD. HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE			
Burial				9/30/72			
24C. NAME of CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)			
Holy Sepulchre				Rochester, New York			
25A. DATE RECD BY HEALTH DEPT.				25B. NAME OF REGISTRAR			
SEP 28 1972				Leonard J Ruck Inc. Baltimore, Md			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

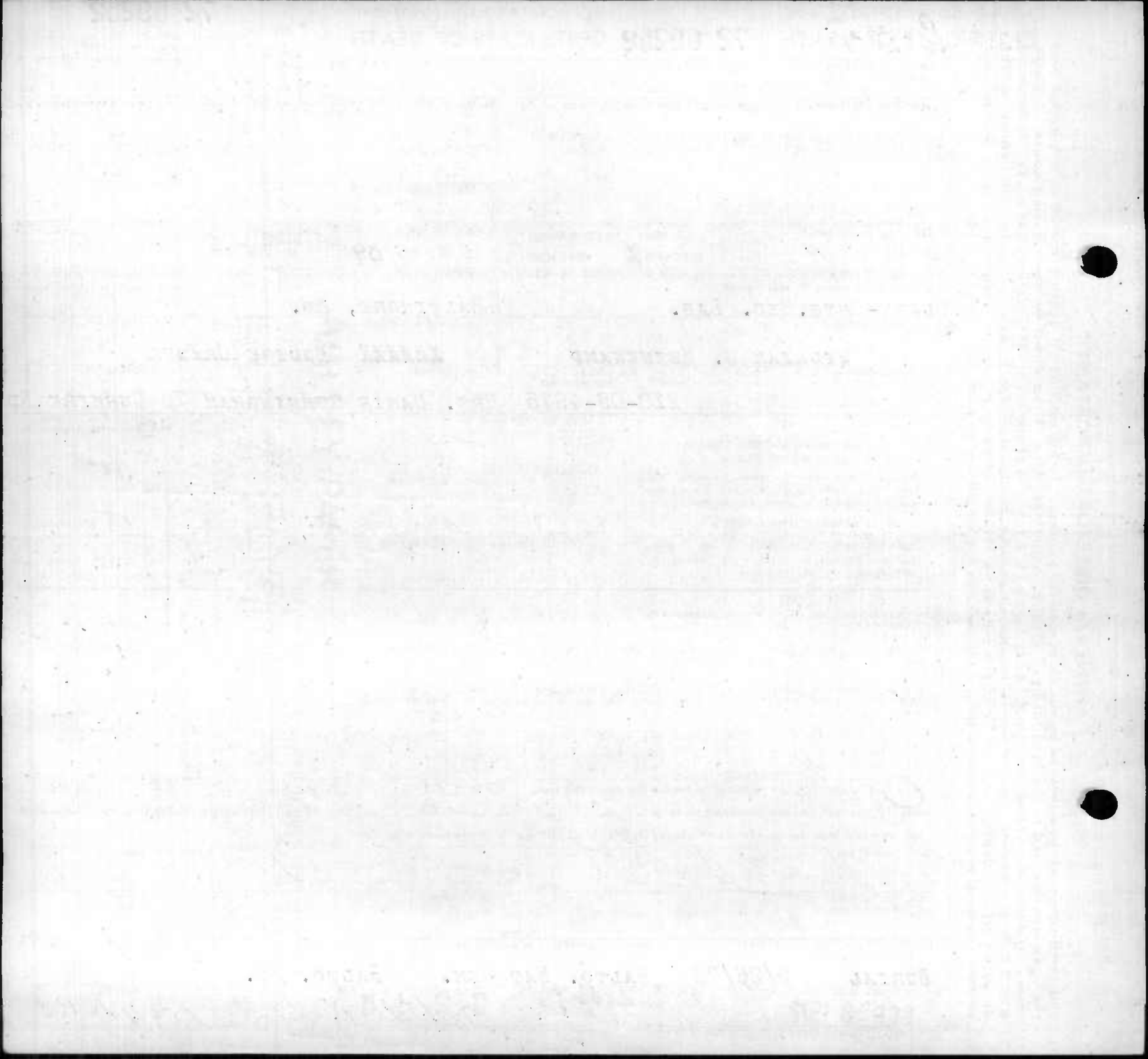
BALTIMORE CITY HEALTH DEPARTMENT				72 09251		REG. NO. 72-9251	
G-623				CERTIFICATE OF DEATH			
BIRTH NO.				STATE OF MARYLAND-DEMH			
1. NAME OF DECEASED (Type or Print) Mr James J. <del>Kenny</del> Geraghty				2. DATE AND HOUR OF DEATH Sept. 23, 1972 5A - M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION  5418 Sagra Road				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. 2710 B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 900 Belgian Ave			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 19, 1892		9. AGE (In years last birthday) 80	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Salesman J.H. Filbert, Inc.				11. BIRTHPLACE (State or foreign country) Baltimore Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James T. Geraghty				14. MOTHER'S MAIDEN NAME Katherine Russell			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 212-01-1729		16. SOCIAL SECURITY NO. 212-01-1729		17. INFORMANT ADDRESS Mrs. J.J. Geraghty 900 Belgian Ave			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  CAUSE OF DEATH Carcinoma of Colon (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from Feb. 19 72 to Sept. 23 19 72 that (I) (we) last saw the deceased alive on Sept. 12 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE W. H. Fetting				23B. DATE SIGNED 9-25-72		23C. PHYSICIAN'S NAME (Type) Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23D. ADDRESS DEGREE							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/26/72		24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery		24D. LOCATION (City, town, or county) (State) Woodlawn, Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 28 1972		25B. NAME OF REGISTRAR Anthony Thornton		25C. FUNERAL DIRECTOR Mitchell Wiedefeld		25D. ADDRESS Home 6500 York Road	



# FUNERAL DIRECTOR: IMPORTANT

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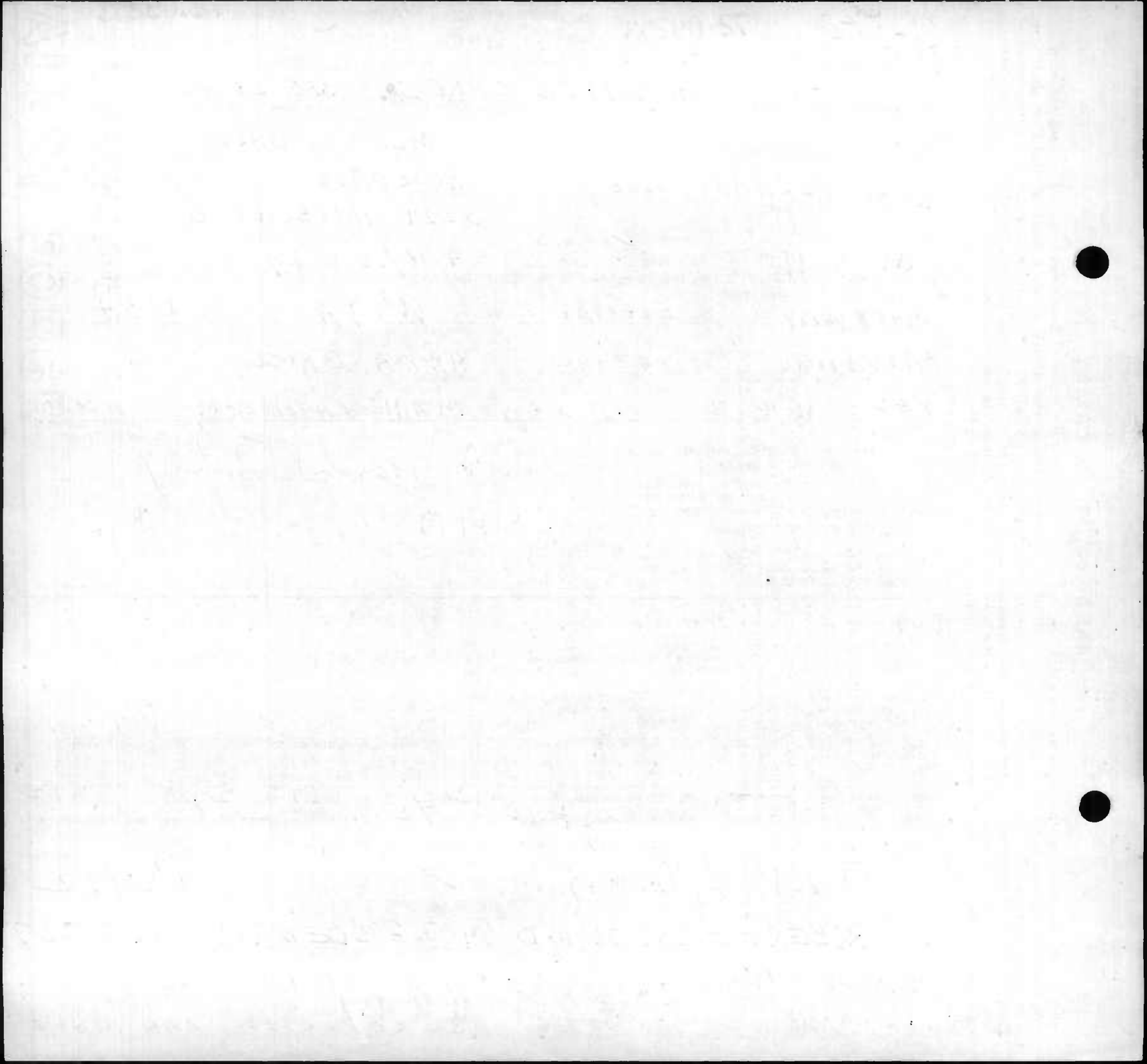
BALTIMORE CITY HEALTH DEPARTMENT				72 09252
72 09252 CERTIFICATE OF DEATH				REG. NO.
BIRTH NO. <b>B-43</b>		STATE OF MARYLAND-DHMH		
1. NAME OF DECEASED (Type or Print) <b>ROSELIND BLACKSTONE</b>		2. DATE AND HOUR OF DEATH <b>9/22/72 6.52 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>U.S.A.</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSPITAL</b> <b>44</b>		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <b>116 W. UNIVERSITY PKWY</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>09-19-09</b>	9. AGE (In years last birthday) <b>63</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK-PHYS. MED. LAB.</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD.</b>
13. FATHER'S NAME <b>WILLIAM G. HEINEKAMP</b>		14. MOTHER'S MAIDEN NAME <b>LOUISE CRAMER</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>218-09-4975</b>		17. INFORMANT ADDRESS <b>MRS. MARIE CUNNINGHAM 75 DUNKIRK RD</b>
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(A) IMMEDIATE CAUSE <b>MYOCARDIAL INFARCTION</b>		<b>1 WK</b>		
(B) DUE TO, OR AS A CONSEQUENCE OF: <b>A. S. C. U. D.</b>		<b>10 years</b>		
(C) _____		_____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		_____		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>09-18</b> 19 <b>72</b> to <b>09-22</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>09-22</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>[Signature]</i>		23B. DATE SIGNED <b>9-22-72</b>		23C. PHYSICIAN'S NAME (Type) <b>DEGREE</b>
23D. ADDRESS <b>DEGREE</b>		23E. FUNERAL DIRECTOR ADDRESS <b>250 York Rd</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>9/26/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>BALTO. NAT CEM.</b>
24D. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 28 1972</b>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				72 09253		72 09253	
C-352				72 09253		72 09253	
BIRTH NO.				REG. NO.		STATE OF MARYLAND - BALTO	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
TONY A. CATONZARO SR.				SEPT. 25 1972			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE		B. COUNTY	
3530 PELHAM AVE				MD.		BALTO	
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				ROSEDALE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER			
				5221 HAZELWOOD			
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
M		W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9/10/25	
						47	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
MACHINIST				ELECTRIC		W. VA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
SALVATORE CATONZARO				ANNA GROSSO			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
YES				WW II		MARIE CATONZARO	
				235-36-5544		A BOVE	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				Myocardial Infarction			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				ASHD.			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from Dec 1967 to Sept 1972, that (I) (we) last saw the deceased alive on Sept 10 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Robert J. Lyden M.D.				9/26/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
ROBERT J. LYDEN M.D.				6402 GOLDENRING RD. 21237			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		9/25/72		GARDENS OF FAITH		BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
SEP 28 1972		Sidney Whitton		J.G. CONNELLY		300 MACE	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

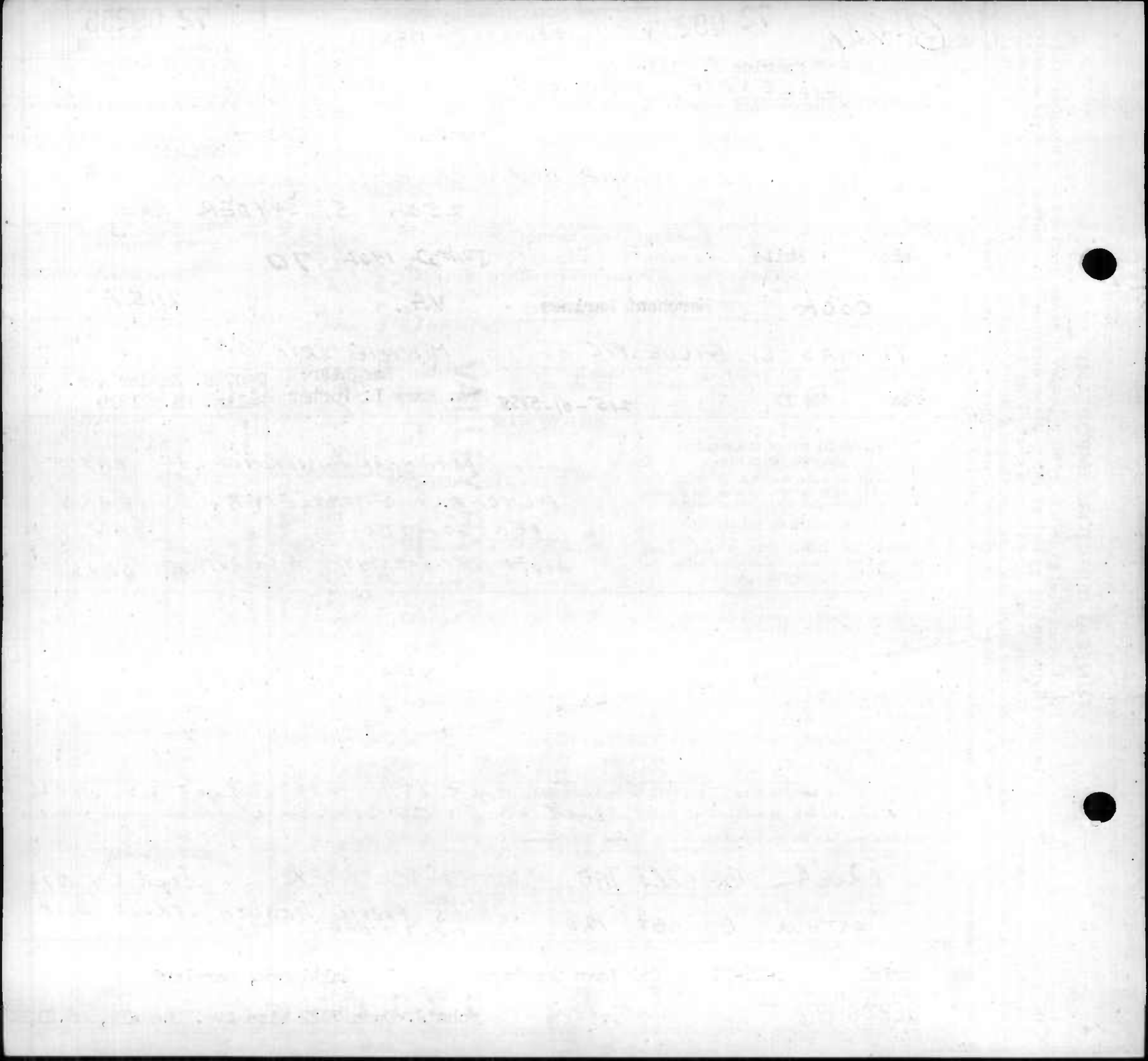
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 09254</b>	
S-420 72 09254				STATE OF MARYLAND-DEATH	
1. NAME OF DECEASED (Type or Print)		N. <b>FRANK SCHLICK</b>		2. DATE AND HOUR OF DEATH <b>09-23-72 12:30 P.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>THE JOHNS HOPKINS HOSPITAL</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>BALTIMORE, MD 21205</b>		C. CITY OR TOWN <b>Dundalk</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>MALE</b>		6. RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>07-28-85</b>		9. AGE (In years last birthday) <b>87</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Production</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>NICHOLAS SCHLICK</b>	
14. MOTHER'S MAIDEN NAME <b>LOUISE SCHULTZ</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-10-0950</b>	
17. INFORMANT <b>Wife:</b> <b>Mrs. Mary B. Schlick</b>		ADDRESS <b>7451 Manchester Road Dundalk, Md. 21222</b>		18. CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>COPD</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>hemosiderosis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CHF</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>CHF</b>		<b>2 yrs.</b>	
(C) <b>anemia - nonresponsive</b>				<b>3 yrs.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Sept. 23 1972</b> to <b>Sept. 23 1972</b> and that (I) (we) last saw the deceased alive on <b>Sept. 23 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Penelope Scott M.D.</b>				23B. DATE SIGNED <b>9/25/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>PENELOPE SCOTT</b>		23D. ADDRESS <b>M.D. THE JOHNS HOPKINS HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-26-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 28 1972</b>		25B. NAME OF REGISTRAR <b>John J. J. J.</b>	
25C. FUNERAL DIRECTOR <b>John J. J. J.</b>		ADDRESS <b>7922 Wise Ave. Dundalk, Md. 21222</b>			

[Faint, mostly illegible text covering the majority of the page, likely bleed-through from the reverse side.]

# FUNERAL DIRECTOR: IMPORTANT

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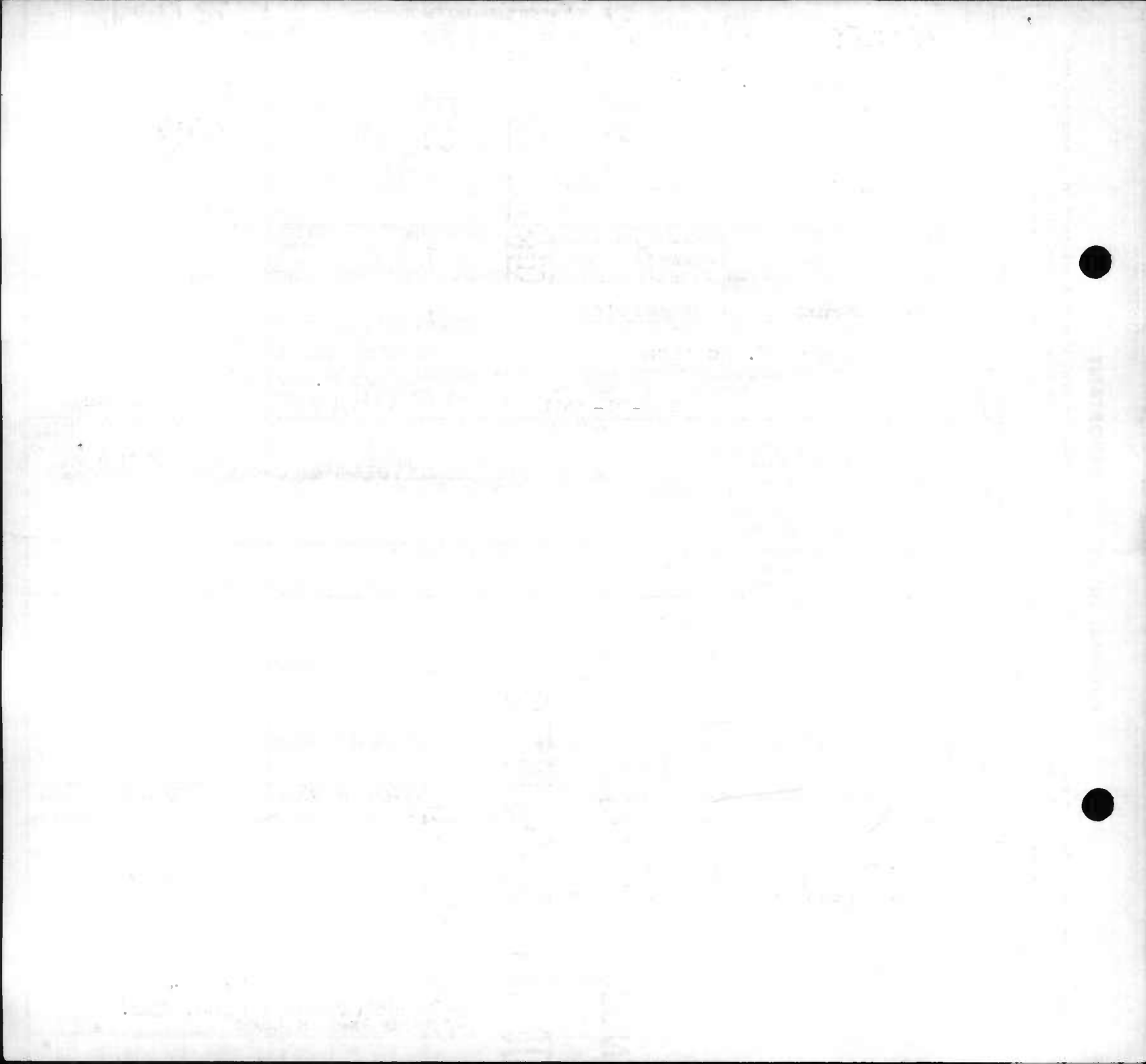
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09255	
G-421 72 09255				CERTIFICATE OF DEATH	
BIRTH NO.		NAME OF DECEASED		DATE AND HOUR OF DEATH	
		Maurice A. Gillespie <i>GILLESPIE, MAURICE</i>		SEPT 23, 1972 6:25 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY	
<i>U.S. PUBLIC HEALTH SERVICE HOSP</i>				<i>Maryland Baltimore</i>	
<i>2 X</i>				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
<i>2507 S. SNYDER AVE.</i>				<i>BALTIMORE</i> YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
<i>Male</i>		<i>White</i>		WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH		9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
<i>JUN 23, 1902</i>		<i>70</i>		<i>COOK</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
<i>VA.</i>		<i>U.S.A.</i>		<i>THOMAS L. GILLESPIE</i>	
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<i>MINNIE MASON</i>		<i>Yes WW II</i>		<i>215-01-5188</i>	
17. INFORMANT		18. CAUSE OF DEATH		19. MEDICAL CERTIFICATION	
<i>Daughter: Mrs. Mary L. Porter</i>		<i>492X I</i>		<i>2507 S. Snyder Ave. Balto. Md. 21219</i>	
20. DATE OF OPERATION		21. CONDITION FOR WHICH OPERATION WAS PERFORMED		22. I certify that (this hospital) attended the deceased from <i>Sept 15</i> 1972 to <i>Sept 23</i> 1972, that (we) last saw the deceased alive on <i>Sept 23</i> 1972 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.	
<i>2</i>		<i>II</i>		<i>Sept 23, 1972</i>	
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
<i>Arthur B. Abt, M.D.</i>		<i>Sept 23, 1972</i>		<i>ARTHUR B. ABT, M.D.</i>	
23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
<i>U.S. PUBLIC HEALTH SERVICE HOSP BALTIMORE MD</i>		<i>Burial</i>		<i>9-26-72</i>	
24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT	
<i>Oak Lawn Cemetery</i>		<i>Baltimore, Maryland</i>		<i>SEP 28 1972</i>	
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS	
<i>John J. Duda</i>		<i>John J. Duda</i>		<i>7922 Wise Ave. Dundalk, Md. 21222</i>	



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. <b>M-255</b>		BALTIMORE CITY HEALTH DEPARTMENT		72 09256		72 09256		STATE OF MARYLAND DEPT	
1. NAME OF DECEASED (Type or Print) <b>MARY J. McMAHON</b>				2. DATE AND HOUR OF DEATH <b>9-21-72 1 4:15 P.M.</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>21213 2643</b>					
FULL NAME OF HOSPITAL OR INSTITUTION <b>MARYLAND GENERAL HOSP.</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <b>48 4006 ELMORA AVE</b>									
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-7-04</b>		9. AGE (In years last birthday) <b>68</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Head Cashier</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Stewart's</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John F. McMahon</b>				14. MOTHER'S MAIDEN NAME <b>Martina Deutsch</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>212-01-9941A</b>				16. SOCIAL SECURITY NO. <b>212-01-9941A</b>		17. INFORMANT <b>Agnes M. Benton</b> sister ADDRESS <b>above</b>			
18. <b>450 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>MASSIVE PULMONARY EMBOLUS</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Massive Pulmonary Embolus</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>± 2 hrs.</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) DUE TO, OR AS A CONSEQUENCE OF:									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>AC</b>		20A. AUTOPSY (Yes or No) <b>AC</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) 1 Month ( ) Day ( ) Year ( ) Hour ( )		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>9/21 19 72</b> to <b>9/21 19 72</b> that (I) (we) last saw the deceased alive on <b>9/21 19 72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>[Signature]</b>				23B. DATE SIGNED <b>9/21/72</b>		23C. PHYSICIAN'S NAME (Type)			
23D. ADDRESS									
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/25/72</b>		24C. NAME of CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>			
25A. DATE RECD BY HEALTH DEPT. <b>SEP 28 1972</b>		25B. NAME OF REGISTRAR <b>[Signature]</b>		25C. FUNERAL DIRECTOR <b>Schmunk Funeral Home, Inc.</b>		ADDRESS <b>3331 Brehms Lane</b>			

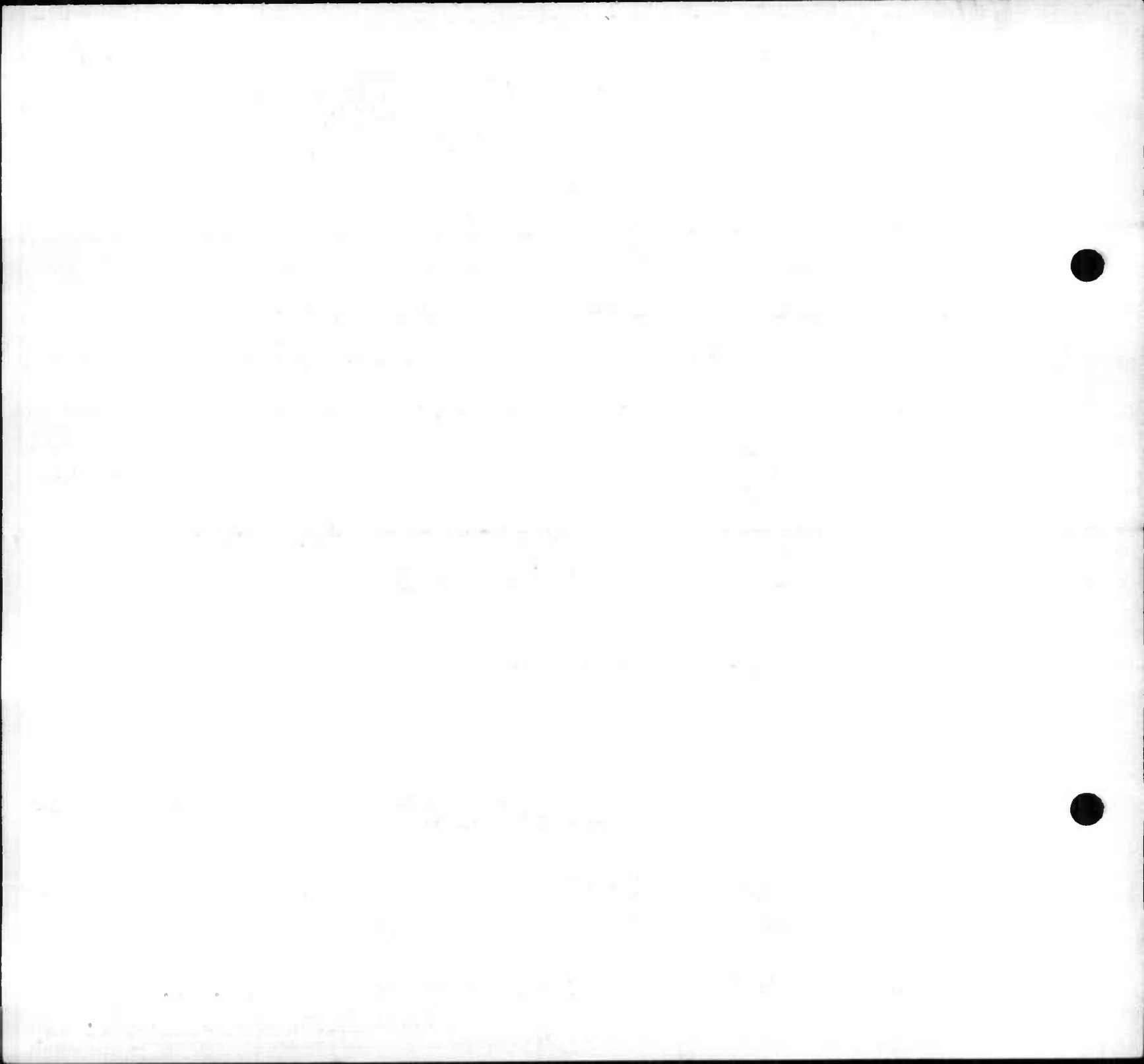




FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 09257</u>	
W-123 72 09257				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>WEBSTER TOWNLEY T</u>		2. DATE AND HOUR OF DEATH <u>9-22-72 6 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>M.D.</u> B. COUNTY <u>CITY</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>NORTH CHARLES GENERAL HOSPITAL BALTIMORE</u>				C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>615 N LINWOOD AVE</u>	
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-10-97</u>	9. AGE (In years last birthday) <u>75</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED RR</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>- RR</u>		11. BIRTHPLACE (State or foreign country) <u>M.D. U.S.A.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>DANIEL WEBSTER</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>705091770</u>		17. INFORMANT <u>N. CHARLES HOSPITAL</u>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>UREMIC COMA</u> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>153.81</u> <u>UREMIC COMA</u> <u>METASTATIC CA, COLON</u> <u>A.S.H.D.</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 DAY</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>A.S.H.D.</u>					
19A. DATE OF OPERATION <u>9-10-72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-</u>		20A. AUTOPSY? (Yes or No) <u>-</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <u>-</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>-</u>	
21D. TIME OF INJURY (Approx.) <u>-</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>-</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>9-10-72</u> to <u>9-22-72</u> that (I) (we) last saw the deceased alive on <u>9-22-72 at 6 P.M.</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>9-22-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>DR. S. K. MITAL</u>				23D. ADDRESS <u>NORTH CHARLES HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/26/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Gardens of Faith Cemetery</u>	
24D. LOCATION <u>Balto. Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 28 1972</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>Schimunek Funeral Homes, Inc.</u>	
				ADDRESS <u>3331 Brehms Lane Balto Md.</u>	





**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-412 72 09258		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		72 19258 STATE OF MARYLAND - BALTIMORE	
1. NAME OF DECEASED (Type or Print) <u>Samuel Wolfson</u>		2. DATE AND HOUR OF DEATH <u>9/25/72</u> <u>6:00 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Sinai Hosp. of Balt.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>2717</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2500 W. Belvedere Ave. 21215</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/22/87</u>	9. AGE (In years lost birthday) <u>85</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tailor</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>SHOP</u>		11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>WOLF WOLFSON</u>			
14. MOTHER'S MAIDEN NAME <u>GOLDIE ?</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>XXXX NO ?</u>			
16. SOCIAL SECURITY NO. <u>213-26-4100</u>		17. INFORMANT <u>WILLIAM WOLFSON, 6505 SANZO ROAD, Apt. A #21209</u>			
18. CAUSE OF DEATH <u>412.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or compulsion which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>Myocardial Insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF: <u>ASCVD</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>months</u> <u>years</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Emphysema</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>9/25</u> 19 <u>72</u> to <u>9/25</u> 19 <u>72</u> that (1) (we) last saw the deceased alive on <u>9/25</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Mar L. Chaiken MD</u>		23B. DATE SIGNED <u>9/25/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Mar L. Chaiken MD</u>	
23D. ADDRESS <u>Sinai Hosp. Balt.</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>			
24B. DATE <u>9/26/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>HEBREW YOUNG MEN</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 28 1972</u>		25B. NAME OF REGISTRAR <u>Aditya</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</u>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09259		REG. NO. 72 09259	
H-632				CERTIFICATE OF DEATH			
BIRTH NO.				STATE OF MARYLAND-DEMD			
1. NAME OF DECEASED (Type or Print) <b>HARTZ, BERNARD</b>				2. DATE AND HOUR OF DEATH <b>9/25/1972 2:20 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SINAI HOSPITAL OF BALTIMORE</b> <b>42</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>E. BELVEDERE AVENUE, 1120</b>			
5. SEX <b>MALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>7/9/07</b> AGE (In years last birthday) <b>65</b>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>LADIES READY-TO-WEAR</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HARTZ, MICHAEL</b>				14. MOTHER'S MAIDEN NAME <b>GERHART, ESTHER</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-07-8458</b>		17. INFORMANT <b>MR. MICHAEL HARTZ, 2418</b>			
				ADDRESS <b>XXXXXX XXXX XXXX</b> <b>XXXXXX DIANA RD.</b>			
18. <b>154.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) <b>ASPIRATION.</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>one day.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <b>RECTAL ADENOCARCINOMA,</b> DUE TO, OR AS A CONSEQUENCE OF:		<b>10 months</b>	
				(C) <b>METASTASIS, INTESTINAL OBST.</b>		<b>10 days</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>23-30-1971</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>RECTAL CARCINOMA</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from <b>9/17/1972</b> to <b>9/24/1972</b> that (H) (we) last saw the deceased alive on <b>9/24/1972</b> and that in (H) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Shobha Joshi</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>9/24/1972</b>	
23C. PHYSICIAN'S NAME (Type) <b>ISRAEL ZINBERG</b>				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>9/26/72</b>		24C. NAME of CEMETERY or CREMATORY <b>BALTIMORE HEBREW</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 28 1972</b>		25B. NAME OF REGISTRAR <b>Audrey Winton</b>		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>			

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 09260

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JOSEPHINE BOOKER</b>				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) (DOA) <b>SOUTH BALTIMORE GENERAL HOSPITAL</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>September 26, 1972 6:15 P.</b> M.			
6. SEX <b>Female</b>		7. RACE <b>White</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>Aug. 12, 1906</b>		10. AGE (In years last birthday) <b>66</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
12. CITIZEN OF <b>U.S.A.</b>		13. FATHER'S NAME <b>John H. Schier</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Presser</b>		15. MOTHER'S MAIDEN NAME <b>Elizabeth Lawton</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>213-03-8586</b>		18. INFORMANT <b>George L. Booker</b>		ADDRESS <b>4134 Hague Ave. 21225</b>	
19. CAUSE OF DEATH <b>412.2</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Hypertensive cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) <b>no</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> M.D. Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>9/27/72</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-30-72</b>		24C. NAME of CEMETERY or CREMATORY <b>Cedar Hill Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 28 1972</b>		25B. NAME OF REGISTRAR <b>Anthony W. Kornblum</b>		25C. FUNERAL DIRECTOR <b>McGully Funeral Home</b>		ADDRESS <b>130 E. Fort Ave. 21230</b>	

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 09261

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JOSEPH A. CLARK</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> <b>September 23, 1972</b>		Hour <b>M.</b>
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>South Baltimore General Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>September 23, 1972 10:17 P.M.</b>		
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>BALTO</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		
6. SEX <b>Male</b>	7. RACE <b>White</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <b>7540 Old Battle Grove Road 21222</b>
9. DATE OF BIRTH <b>MAY 25, 1948</b>		10. AGE (In years last birthday) <b>24</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>EDWARD J. CLARK, JR.</b>		
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRUCK MECHANIC</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>CLARKS AUTO. REP.</b>		15. MOTHER'S MAIDEN NAME <b>SOPHIE GOLDS</b>
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES VIETNAM 1969</b>		17. SOCIAL SECURITY NO. <b>216-54-4957</b>		18. INFORMANT ADDRESS <b>E-CLARK 7540 Old BATTLE GROVE</b>
19. <b>E970X 1971</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>Yes</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>street</b>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>at 1400 Covington Street 2402</b>
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>9-23-72 9:53 P.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Shot by police officer</b>
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Marvin S. Platt, M.D.</b> M.D. EXAMINER'S NAME (Type)  CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>September 24, 1972</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>9-27-72</b>	24C. NAME OF CEMETERY OR CREMATORIUM <b>GARDENS OF FAITH</b>	24D. LOCATION (City, town, or county) (State) <b>BALTO. CO. MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 28 1972</b>		25B. NAME OF REGISTRAR <b>Anthony [illegible]</b>		25C. FUNERAL DIRECTOR ADDRESS <b>W. FALKOWSKI 2007 EASTERN</b>



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1. NAME OF DECEASED (Type or Print) <b>BOB JONES</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>561 Laurens St.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>9 26 1972 2:45a</b> M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1402</b>			
6. SEX <b>male</b>	7. RACE <b>negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN <b>Balto.</b>
9. DATE OF BIRTH	10. AGE (In years last birthday) <b>102</b>	11. Under 1 Yr. 12 Under 24 Hrs. Months Days Hours Min.	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of the bowel</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>no</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <u>Russell S. Fisher</u> M.D. EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b> DATE SIGNED <b>9-26-72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/1/72</b>	
24C. NAME of CEMETERY or CREMATORY <b>Restlawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Sanford, Florida</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 28 1972</b>		25B. NAME OF REGISTRAR <u>Anthony Robinson</u>	
25C. FUNERAL DIRECTOR <u>Robert L. Lanthier</u>		ADDRESS <u>805 Madison Ave</u>	

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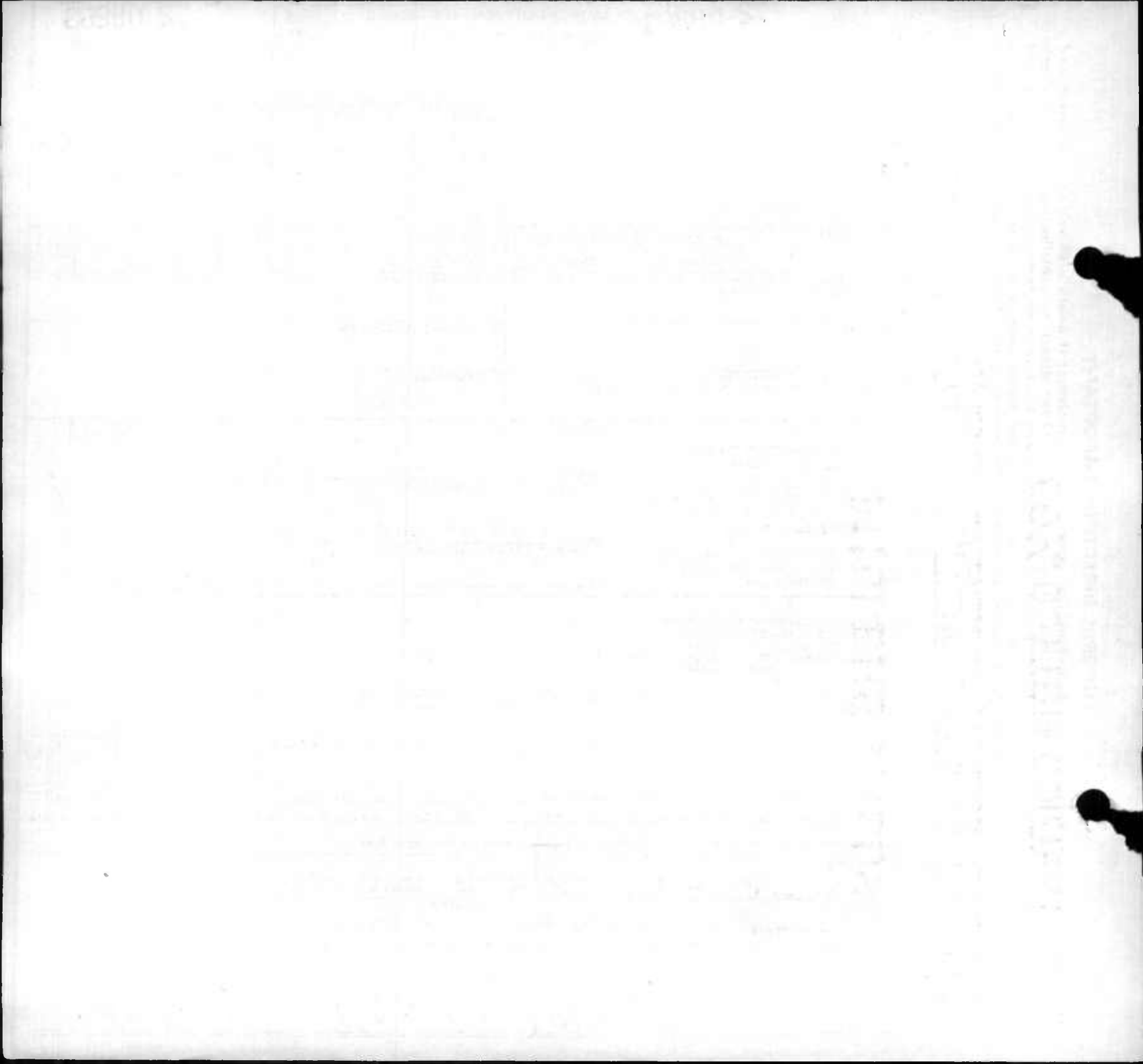
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

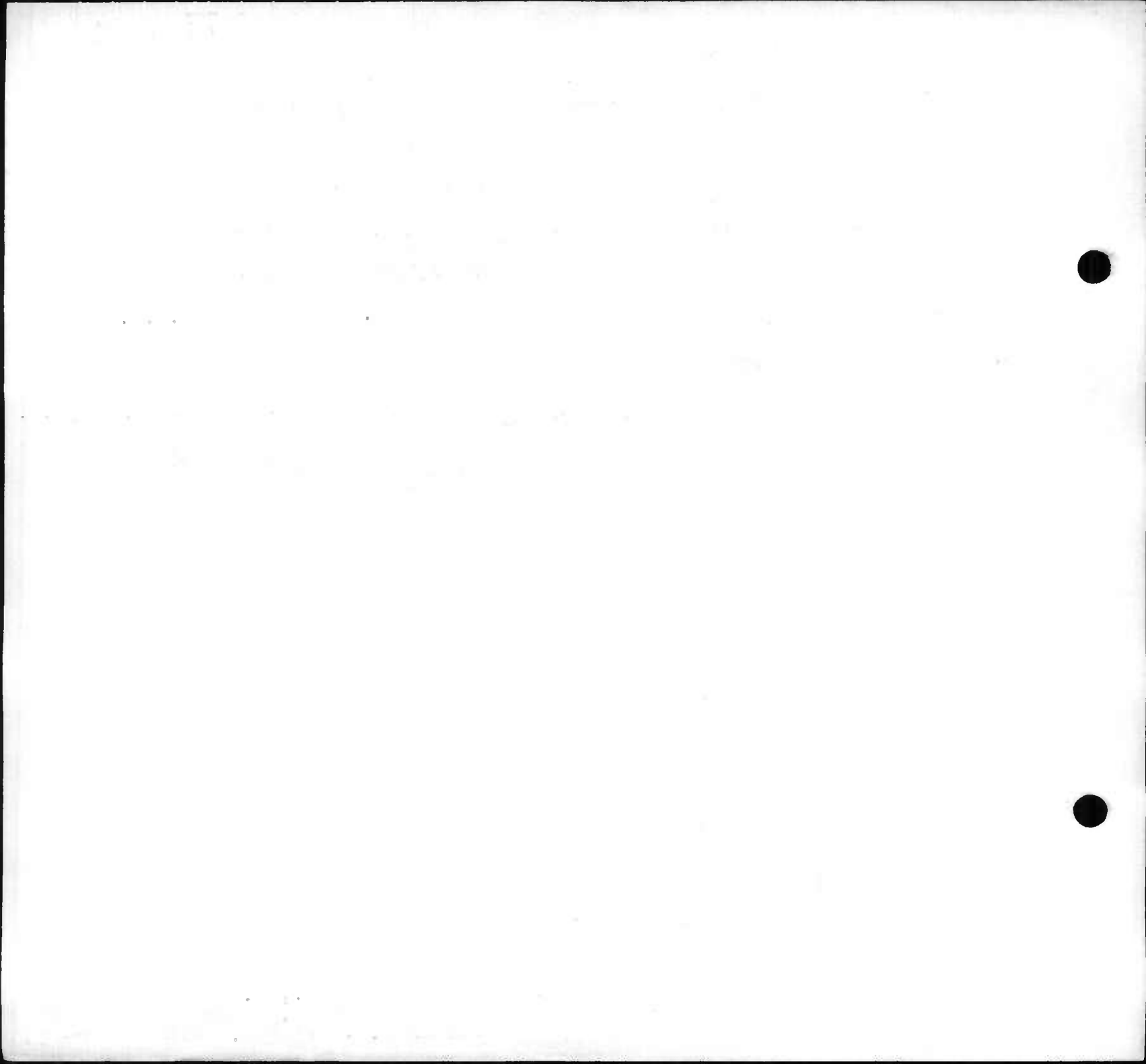
BALTIMORE CITY HEALTH DEPARTMENT				72 09263		72 09263	
H-200				72 09263		72 09263	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Herbert A Hozey				September 25, 1972 3:20 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION				A. STATE			
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				B. COUNTY			
48 Md. General Hospital				Md.			
5. SEX				6. RACE			
M				N			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				8. DATE OF BIRTH			
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				11-12-13			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)			
None				US			
13. FATHER'S NAME				12. CITIZEN OF WHAT COUNTRY?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
Unknown				UNKNOWN			
17. INFORMANT				ADDRESS			
Chart.				18. 470.91			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE			
ANTECEDENT CAUSES				DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Acute myocardial infarction 12 hrs			
II				Anteriosclerotic cardiovascular disease			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Approx.)			
21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?			
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				22. I certify that (I) (this hospital) attended the deceased from September 25 1972 to September 25 1972			
23A. SIGNATURE				23B. DATE SIGNED			
James H Biddison, M.D.				9/25/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
JAMES H BIDDISON, M.D.				Md. General Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE			
Burial				9/28/72			
24C. NAME of CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)			
Mt. Auburn Cemetery				Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR			
SEP 28 1972				MAY E. LAW			
25C. FUNERAL DIRECTOR				ADDRESS			
MAY E. LAW				802 Madison Ave.			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09264	
CERTIFICATE OF DEATH				REG. NO. 72 09264	
STATE OF MARYLAND				DEPT. OF HEALTH	
1. NAME OF DECEASED (Type or Print) <u>Forrester, Richard</u>		2. DATE AND HOUR OF DEATH <u>9/26/72 9:25</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Lutheran Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>1501</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>46 Lutheran Hospital</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>1557 Gilmore St</u>		5. SEX <u>M</u>		6. RACE <u>Negro</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/24/05</u>		9. AGE (in years last birthday) <u>67</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>construction worker</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Clarence Forrester</u>		14. MOTHER'S MAIDEN NAME <u>Matilda Simms</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-07-2492</u>		17. INFORMANT <u>Mary Irby 160 Spruce St. Newark, N.J.</u>	
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Acute myocardial infarction.</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>9-26-72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>NO</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9-26-72</u> to <u>9-26-72</u> and that (I) (we) last saw the deceased alive on <u>9-26-72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>C.V. Lucas MD</u>		23B. DATE SIGNED <u>9-26-72</u>			
23C. PHYSICIAN'S NAME (Type) <u>C.V. LUCAS MD</u>		23D. ADDRESS <u>Lutheran Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-30-72</u>		24C. NAME of CEMETERY or CREMATORY <u>Arbutus Mem. Park</u>	
24D. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 28 1972</u>		25B. NAME OF REGISTRAR <u>A. Bailey</u>		25C. FUNERAL DIRECTOR <u>W. Bailey</u>	
25D. ADDRESS <u>1348 N. Calhoun Street</u>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>72 09265</p> <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p><b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. 72 09265</p> <p>STATE OF MARYLAND - DEATH</p>	
<p>BIRTH NO. <u>525</u></p> <p>1. NAME OF DECEASED (Type or Print) <u>Johnson, Arthur</u></p>		<p>2. DATE AND HOUR OF DEATH <u>September 23, 1972 8:45 AM</u> M.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION <u>90 Bolton Hill Nursing Home</u></p> <p>IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION</p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</p> <p>A. STATE <u>Maryland</u> B. COUNTY <u>1301</u></p> <p>C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <u>2553 Madison Avenue 21217</u></p>	
<p>5. SEX <u>Male</u></p>	<p>6. RACE <u>Black</u></p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>1-15-02</u></p>
<p>9. AGE (In years last birthday) <u>70 yrs.</u></p>		<p>If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.</p>	<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor night watchman</u></p>
<p>10B. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u></p>	<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>
<p>13. FATHER'S NAME <u>Wm. Johnson</u></p>		<p>14. MOTHER'S MAIDEN NAME <u>Annie Harriday</u></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>unknown</u></p>		<p>16. SOCIAL SECURITY NO. <u>217-05-0876</u></p>	<p>17. INFORMANT <u>Helen Johnson</u> ADDRESS <u>1735 Bentalou st.</u></p>
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.</p>		<p>CAUSE OF DEATH</p> <p>(A) IMMEDIATE CAUSE <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF: <u>1 Week</u></p> <p>(B) <u>Advanced ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Years</u></p> <p>(C) _____</p>	
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION <u>0</u></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No) _____</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (H) (this hospital) attended the deceased from <u>March 21</u> 19 <u>72</u> to <u>September 23</u> 19 <u>72</u> that (H) (we) last saw the deceased alive on <u>September 23</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <u>Peter H. Rheinstein, MD</u></p>		<p>23B. DATE SIGNED <u>Sept. 23, 1972</u></p>	
<p>23C. PHYSICIAN'S NAME (Type) <u>PETER H. RHEINSTEIN, MD</u></p>		<p>23D. ADDRESS <u>Bolton Hill Nursing Home</u></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u></p>		<p>24B. DATE <u>9-26-72</u></p>	
<p>24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Mem. Pk.</u></p>		<p>24D. LOCATION (City, town, or county) <u>Balto., Md.</u> (State) _____</p>	
<p>25A. DATE RECD BY HEALTH DEPT. <u>SEP 28 1972</u></p>		<p>25B. NAME OF REGISTRAR <u>Admiral Johnson</u></p>	
<p>25C. FUNERAL DIRECTOR <u>V. Bailey</u></p>		<p>ADDRESS <u>Baltimore, F.I. 1348 Calhoun Street</u></p>	

10-05-06



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 09266

BIRTH NO.

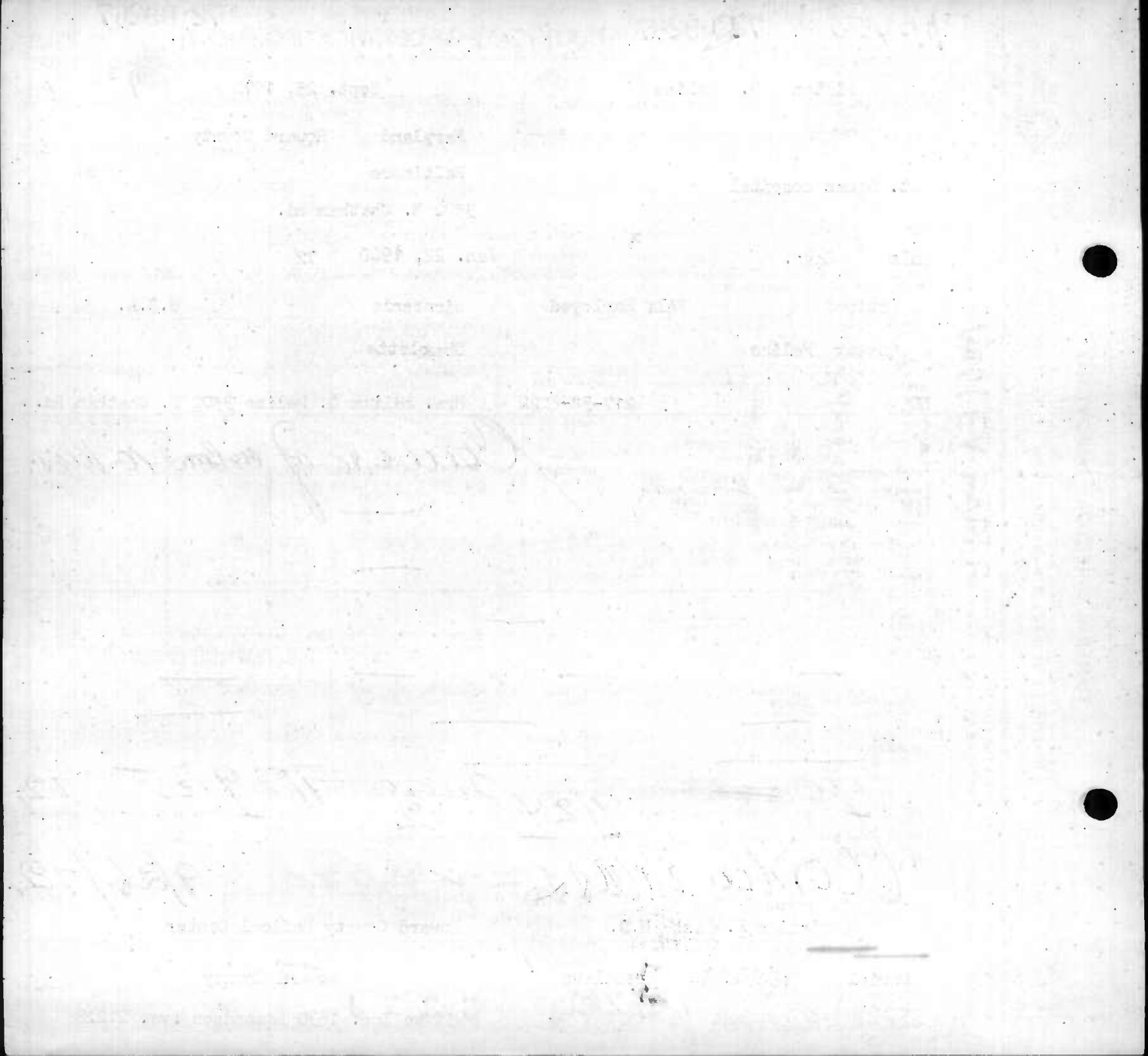
1. NAME OF DECEASED (Type or Print) <b>LUCIUS MORGAN Jackson</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>3715 Liberty Heights Ave.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>9 24 1972 12:45p</b> M.	
6. SEX <b>male</b>		7. RACE <b>negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>9-23-39</b>		10. AGE (In years last birthday) <b>33</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Virgin Jackson</b>		ADDRESS <b>same</b>	
19. <b>E95013</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Darvon intoxication</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>House</b>	
22D. TIME OF INJURY (APPROX.) Month Day Year Hour <b>9-24-72 ? m.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? <b>Took overdose</b>		21. AUTOPSY? (Yes or No) <b>yes</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Marvin S. Platt</b> EXAMINER'S NAME (Type) <b>Marvin S. Platt, M.D.</b>		DATE SIGNED <b>9-25-72</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-28-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Mem. Pk.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE RECEIVED BY HEALTH DEPT. <b>SEP 28 1972</b>		25B. NAME OF REGISTRAR <b>Edith H. Bailey</b>	
25C. FUNERAL DIRECTOR <b>Kelson D.H.</b>		ADDRESS <b>1348 Calhoun Street</b>	

10-27-1972 - Completion of cause of death on a pending medical examiner death certificate-  
Marvin S. Platt, M.D. HRS

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-450 72 09267				BALTIMORE CITY HEALTH DEPARTMENT		72 09267	
BIRTH NO.				CERTIFICATE OF DEATH		REG. NO. <del>72 09267</del> OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print) <b>Milton G. Meline</b>				2. DATE AND HOUR OF DEATH <b>Sept. 25, 1972 9<sup>30</sup> A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Agnes Hospital</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Howard County</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>3502 N. Chatham Rd.</b>			
5. SEX <b>Male</b>	6. RACE <b>Cauc.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 22, 1900</b>	9. AGE (In years last birthday) <b>72</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>		11. BIRTHPLACE (State or foreign country) <b>Minnesota</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Gustav Meline</b>				14. MOTHER'S MAIDEN NAME <b>Charlette</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217-32-8222</b>		17. INFORMANT ADDRESS <b>Mrs. Milton G. Meline 3502 N. Chatham Rd.</b>			
18. <b>153.81</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>Cancer of colon 10 mos.</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <b>9/24/72</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <input type="checkbox"/> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
22. I certify that (I) (this hospital) attended the deceased from <b>9/24/72</b> to <b>9/25/72</b> that (I) (we) last saw the deceased alive on <b>9/24/72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Christian S. Mass, M.D.</b>				23B. DATE SIGNED <b>9/26/72</b>		23C. PHYSICIAN'S NAME (If not Christian S. Mass, M.D.) <b>Howard County Medical Center</b>	
24A. BURIAL <input checked="" type="checkbox"/> CREMATION <input type="checkbox"/> (Specify) <b>Burial</b>				24B. DATE <b>9/28/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Crestlawn</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 28 1972</b>				25B. NAME OF REGISTRAR <b>Witzke Inc.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>1630 Edmondson Ave. 21228</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09268		72 09268	
BIRTH NO.				72 09268		72 09268	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
HOBBS, ETHEL				SEPTEMBER 24, 1972		8:45 P.M.	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY				MD. 1401			
5. SEX FEMALE				6. RACE WHITE			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				8. DATE OF BIRTH 09 17 98			
9. AGE (In years lost birthday) 74				10. AGE (In years lost birthday) 74			
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME EDMUND HAEFNER				14. MOTHER'S MAIDEN NAME BERTHA ( DILLOW) HAEFNER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 216 03 5265			
17. INFORMANT 55 ST AGNES RECORDS WILKENS & CATON AVES				ADDRESS			
18. 438.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (X) (this hospital) attended the deceased from SEPTEMBER 17, 1972 to SEPTEMBER 24, 1972. that (X) (we) last saw the deceased alive on SEPTEMBER 24, 1972 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. 23A. SIGNATURE Dr. Percy Dour 23B. DATE SIGNED 9-24-72 23C. PHYSICIAN'S NAME (Type) DEKHOREGHANI FEREYDOUN, MD. 23D. ADDRESS WILKENS & CATON AVE. BALTO. MD. 21229 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 9/27/72 24C. NAME OF CEMETERY or CREMATORY Meadowridge 24D. LOCATION (City, town, or county) (State) Dorsey, Maryland 25A. DATE REC'D BY HEALTH DEPT SEP 28 1972 25B. NAME OF REGISTRAR Aldrey W. Witzke 25C. FUNERAL DIRECTOR Witzke, 1430 Edmondson Avenue 25D. ADDRESS 212 28							

MEMORANDUM FOR THE DIRECTOR

RE: [Illegible]

DATE: [Illegible]

BY: [Illegible]

SUBJECT: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09269		72 09269	
BIRTH NO.				72 09269		72 09269	
1. NAME OF DECEASED (Type or Print) <b>Margaret Arnold</b>				2. DATE AND HOUR OF DEATH <b>Sept 25 1972 3:20 PM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Edgewood Nursing Home</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2712</b>			
5. SEX <b>F</b>				6. RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Companion</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Companion</b>		8. DATE OF BIRTH <b>5/20/88</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>		9. AGE (In years last birthday) <b>84</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>220-38-5393A</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
17. INFORMANT <b>Felix Morrison, 796 Locust Circle Bayberry, Arnold, Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardio-Vascular Dis.</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>YEARS -</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Periphereal Vascular Disease</b>		YEARS -	
				(B) DUE TO, OR AS A CONSEQUENCE OF: <b>ARTERIOSCLEROSIS -</b>		YEARS -	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>9-25-72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>10/18/67</b> to <b>9/25/72</b> that (I) (we) last saw the deceased alive on <b>9-25-72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Anthony F. Carozza</b>				23B. DATE SIGNED <b>9-25-72</b>			
23C. PHYSICIAN'S NAME (Type) <b>Anthony F. Carozza</b>				23D. ADDRESS <b>5217 York Rd Balto Md 21212</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-27-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH, DEPT. <b>SEP 28 1972</b>		25B. NAME OF REGISTRAR <b>Anthony F. Carozza</b>		25C. FUNERAL DIRECTOR <b>Nicholas T. Matthews</b>		ADDRESS <b>3021 Eastern Ave., Baltimore, Md.</b>	

10/18/67

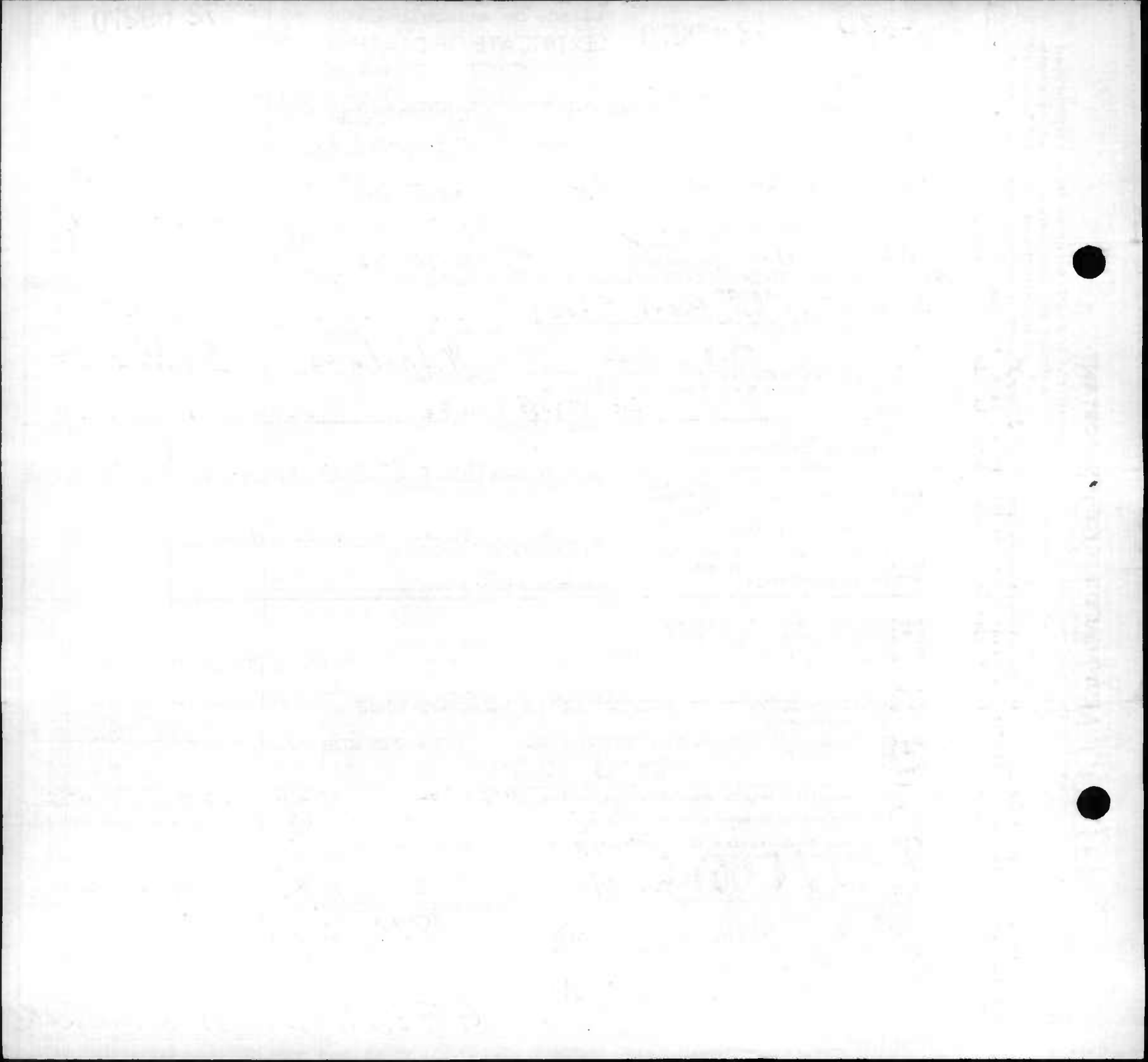
Former address unknown



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

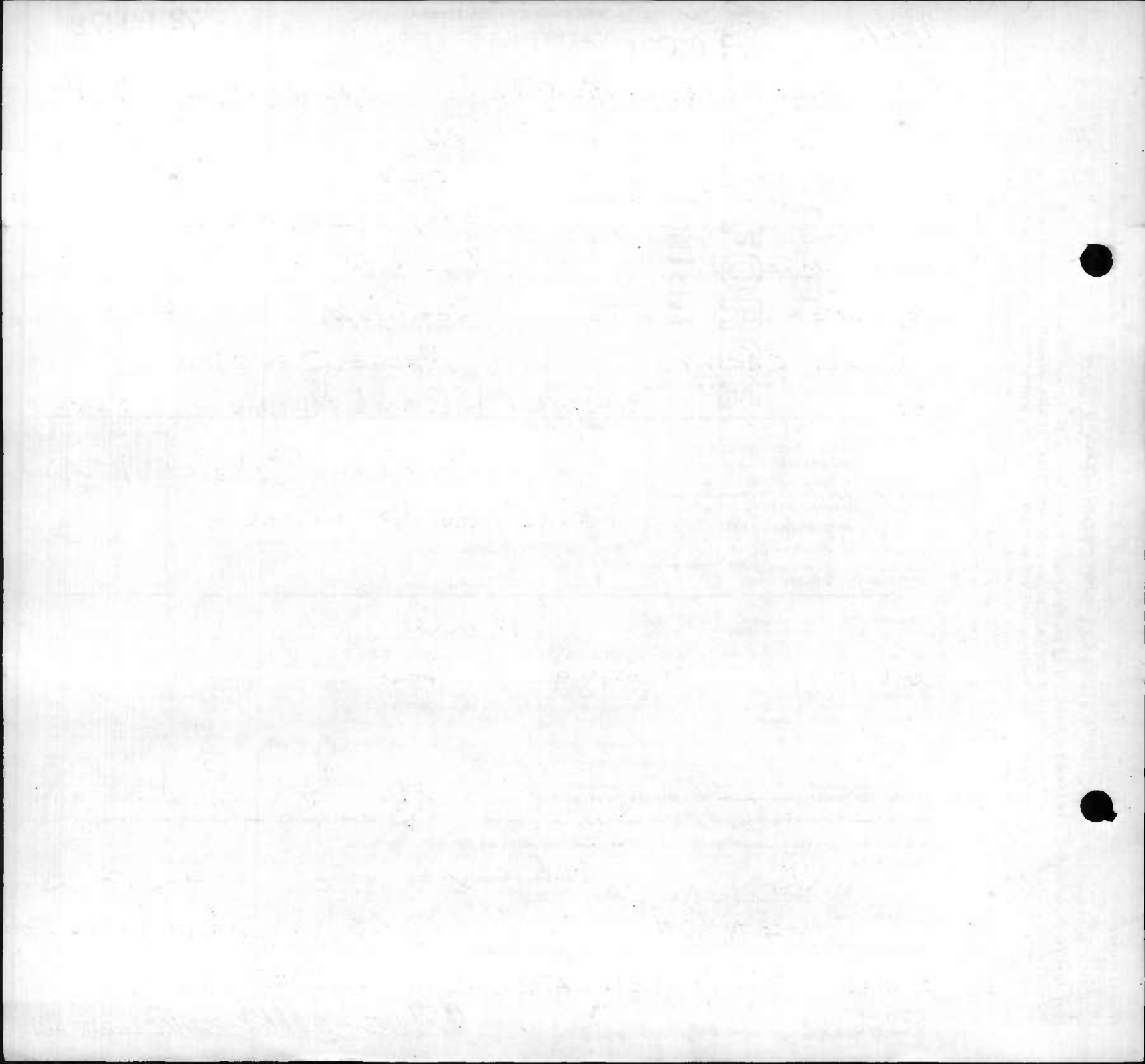
S-530 72 09270		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 09270
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>EARL L. Schmidt</b>		2. DATE AND HOUR OF DEATH <b>9-25-72 12:35 A.M.</b>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>BALTO</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>MARYLAND General Hosp.</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <b>M</b> 6. RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-10-06</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Accounting Dept.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Beth Steel</b>		9. AGE (in years lost birthday) <b>65</b>
13. FATHER'S NAME <b>Charles Schmidt</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-076236</b>		17. INFORMANT <b>Wife</b>
18. <b>436.01</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Blot Cerebral Vascular Accident</b>		<b>1<sup>st</sup> CVA 1968</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Arteriosclerotic vascular disease</b>		
		(C) <b>Hypertension</b>		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Indicate medical condition)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>9/23/72</b> to <b>9/25</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>9/25</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Arnold G. Alexander MD</b>		23B. DATE SIGNED <b>9/25/72</b>		23C. PHYSICIAN'S NAME (Type) <b>Arnold G. Alexander MD</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>9/28/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>PARKVIEW</b>
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 28 1972</b>		25B. NAME OF REGISTRAR <b>Audrey Whitson</b>		25C. FUNERAL DIRECTOR <b>G. F. EVANSTON</b>
				ADDRESS <b>8802 HANCOCK RD</b>



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

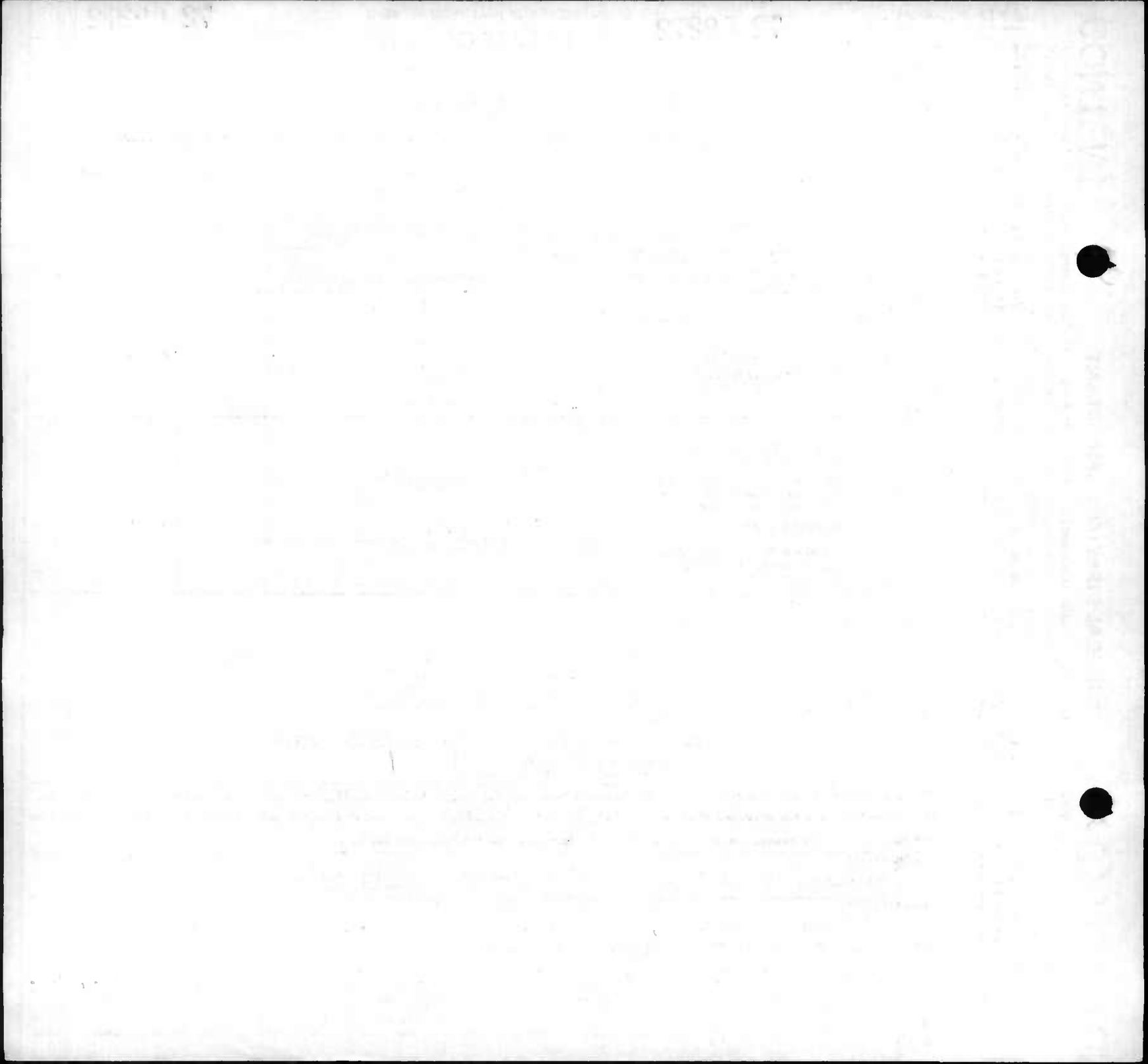
BIRTH NO. <b>M-610</b>		72 09271		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 09271</b>	
1. NAME OF DECEASED (Type or Print) <b>EMILY VIRGINIA MURPHY</b>				2. DATE AND HOUR OF DEATH <b>SEPT. 23, 1972 7 P. M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>2641</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>00 4207 BERGER AVE</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTO</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>4207 BERGER AVE</b>		5. SEX <b>FEMALE</b>		6. RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>DEC. 2, 1915 56</b>		9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		11. BIRTHPLACE (State or foreign country) <b>BALTO., MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>RICHARD BROWN</b>		14. MOTHER'S MAIDEN NAME <b>MAUDE BAUGHER</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>217-24-8631</b>		17. INFORMANT <b>WILLIAM L. MURPHY</b>		ADDRESS <b>SAME</b>		18. CAUSE OF DEATH <b>153.81</b>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Carcinoma Colon</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Metastases to liver</b>		(C) <b>None</b>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>None</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>			
19A. DATE OF OPERATION <b>Oct 1971</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>above</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Sept. 1971</b> to <b>Sept. 1972</b> , that (I) (we) last saw the deceased alive on <b>Sept. 22 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <b>W. Benson Jr. MD</b>				23B. DATE SIGNED <b>9-25-72</b>		23C. PHYSICIAN'S NAME (Type) <b>WBENSON</b>	
23D. ADDRESS <b>3506 N. Calvert 21218</b>				23E. DATE REC'D BY HEALTH DEPT. <b>SEP 28 1972</b>		23F. NAME OF REGISTRAR <b>A. J. Halter</b>	
23G. FUNERAL DIRECTOR <b>J. Halter</b>				23H. ADDRESS <b>5444 BELAIR Rd.</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	
24B. DATE <b>9-27-72</b>				24C. NAME OF CEMETERY or CREMATORIUM <b>NEW CATHEDRAL</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO., MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 28 1972</b>							



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <span style="font-size: 2em;">72 09272</span> STATE OF MARYLAND-DHME
<b>BIRTH NO.</b> <span style="font-size: 1.5em;">S-530</span> <span style="font-size: 1.5em;">72 09272</span> <b>BALTO CO. MD.</b>		<b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">Schmitt, Rebecca</span>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> <span style="font-size: 1.2em;">Johns Hopkins Hospital</span>		<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">9-23-72 9:07 P</span>		
<b>5. SEX</b> <span style="font-size: 1.2em;">F</span> <b>6. RACE</b> <span style="font-size: 1.2em;">W</span> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) <b>A. STATE</b> <span style="font-size: 1.2em;">Maryland</span> <b>B. COUNTY</b> <span style="font-size: 1.2em;">5300</span>		
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Newborn</span>		<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">9-20-72</span> <b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">3 days</span>		
<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">—</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">St. Joseph Hospital Maryland</span>		
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Gerard Schmitt</span>		<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Malonna (Last not known)</span>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">—</span>		
<b>17. INFORMANT</b> <span style="font-size: 1.2em;">Father</span>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">US</span>		
<b>18. CAUSE OF DEATH</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <div style="text-align: center; font-weight: bold;">II</div> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b>				<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <span style="font-size: 1.2em;">10H-15mins</span>  <span style="font-size: 1.2em;">10H-15m</span>
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">—</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <span style="font-size: 1.2em;">—</span>		<b>20A. AUTOPSY (Yes or No)</b> <span style="font-size: 1.2em;">Yes</span>
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Indify medical examined) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <span style="font-size: 1.2em;">—</span>		<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b> <span style="font-size: 1.2em;">No</span>
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) <span style="font-size: 1.2em;">—</span>		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR</b> <span style="font-size: 1.2em;">—</span>
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.2em;">21 Sept 1972</span> <b>to</b> <span style="font-size: 1.2em;">23 Sept 1972</span> <b>that (I) (we) last saw the deceased alive on</b> <span style="font-size: 1.2em;">9:07 pm 9/23/72</span> <b>and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.</b>				
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">James Rubenstein</span> <span style="float: right;">M.D.</span>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">9/23/72</span>
<b>23C. PHYSICIAN'S NAME (Type)</b> <span style="font-size: 1.2em;">James Rubenstein, M.D.</span>				<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">Box 316 - Johns Hopkins Hosp</span>
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <span style="font-size: 1.2em;">Cremation</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">9/24/72</span>		<b>24C. NAME OF CEMETERY OR CREMATORY</b> <span style="font-size: 1.2em;">Johns Hopkins Hospital</span>
<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">601 N Broadway Balto., Md.</span>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">SEP 28 1972</span> <b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">—</span> <b>25C. ADDRESS</b> <span style="font-size: 1.2em;">—</span>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09273	
CERTIFICATE OF DEATH				STATE OF MARYLAND - DHMH	
BIRTH NO. <u>S-14072-14547</u>		72 09273		REG. NO. <u>72 09273</u>	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		M.	
JACQUELINE DELORES SHIPLEY		9-21-72		12:36 P	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>THE JOHNS HOPKINS HOSPITAL</u> <u>33</u>			A. STATE B. COUNTY <u>MARYLAND</u> <u>1503</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN D. (INSIDE CITY LIMITS?)		
			BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER <u>2103 W. NORTH AVE.</u>		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
FEMALE	NEGRO	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9-19-72		2
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Johns Hopkins Hospital Baltimore, Maryland	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
EARL SHIPLEY					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
18. <u>772.01</u>			CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Respiratory Arrest</u> <u>4 1/2 hrs.</u>		
ANTECEDENT CAUSES			(B) <u>Prematurity</u> <u>2 days.</u>		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) <u>? CNS bleed, pulmonary hemorrhage</u> <u>9 1/2 hrs.</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>Sept. 21</u> 19 <u>72</u>					
that (I) (we) last saw the deceased alive on <u>Sept. 21</u> 19 <u>72</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
<u>J. E. Graeber MD.</u>			<u>9/21/72</u>		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
J. E. GRAEBER			THE JOHNS HOPKINS HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Cremation		9/22/72		Johns Hopkins Hospital	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FULL ADDRESS	
SEP 28 1972		<u>Anthony M. Brown</u>		MORTUARY SERVICE - BCHD	



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**FUNERAL DIRECTOR: IMPORTANT**

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BALTIMORE CITY HEALTH DEPARTMENT									
C-500 72 09274 CERTIFICATE OF DEATH									
REG. NO. 72 09274									
BIRTH NO.									
1. NAME OF DECEASED (Type or Print) COONEY, DOROTHY A					2. DATE AND HOUR OF DEATH SEPTEMBER 25, 1972 7:10A.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  40 ST. AGNES HOSPITAL					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? APXXXXXXXXXXXXX YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER APT 217 OAKLEE VILLAGE 21229				
5. SEX FEMALE	6. RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 05/29/97	9. AGE (In years last birthday) 75	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) MARYLAND XXXXXXXX		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME THOMAS BAZELL					14. MOTHER'S MAIDEN NAME MARY SCHAEFER BAZEL				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS ST. AGES HOSPITAL RECORDS				
18. 4310 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). A. IMMEDIATE CAUSE Respiratory failure B. Cerebral hemorrhage C. Hypertension									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
MEDICAL CERTIFICATION									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 20, 1972 to SEPTEMBER 25, 1972, that (I) (we) last saw the deceased alive on SEPTEMBER 25, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Donald Tsai					23B. DATE SIGNED Sept 25 '72			23C. PHYSICIAN'S NAME (Type) D. TSAI, M.D.	
23D. ADDRESS BALTIMORE, MD 21229 ST. AGNES HOSPITAL; CATON & WILKENS AVES					23E. ATTENDING PHYSICIAN Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 9-28-1972		24C. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery			24D. LOCATION (City, town, or county) (State) Washington Blvd. Howard Geo. Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 28 1972			25B. NAME OF REGISTRAR Audrey H. Heston			25C. FUNERAL DIRECTOR Hubbard Funeral Home			25D. ADDRESS 4107 Wilkens Ave.

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COONEY, JOHN W.

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# FUNERAL DIRECTOR: IMPORTANT

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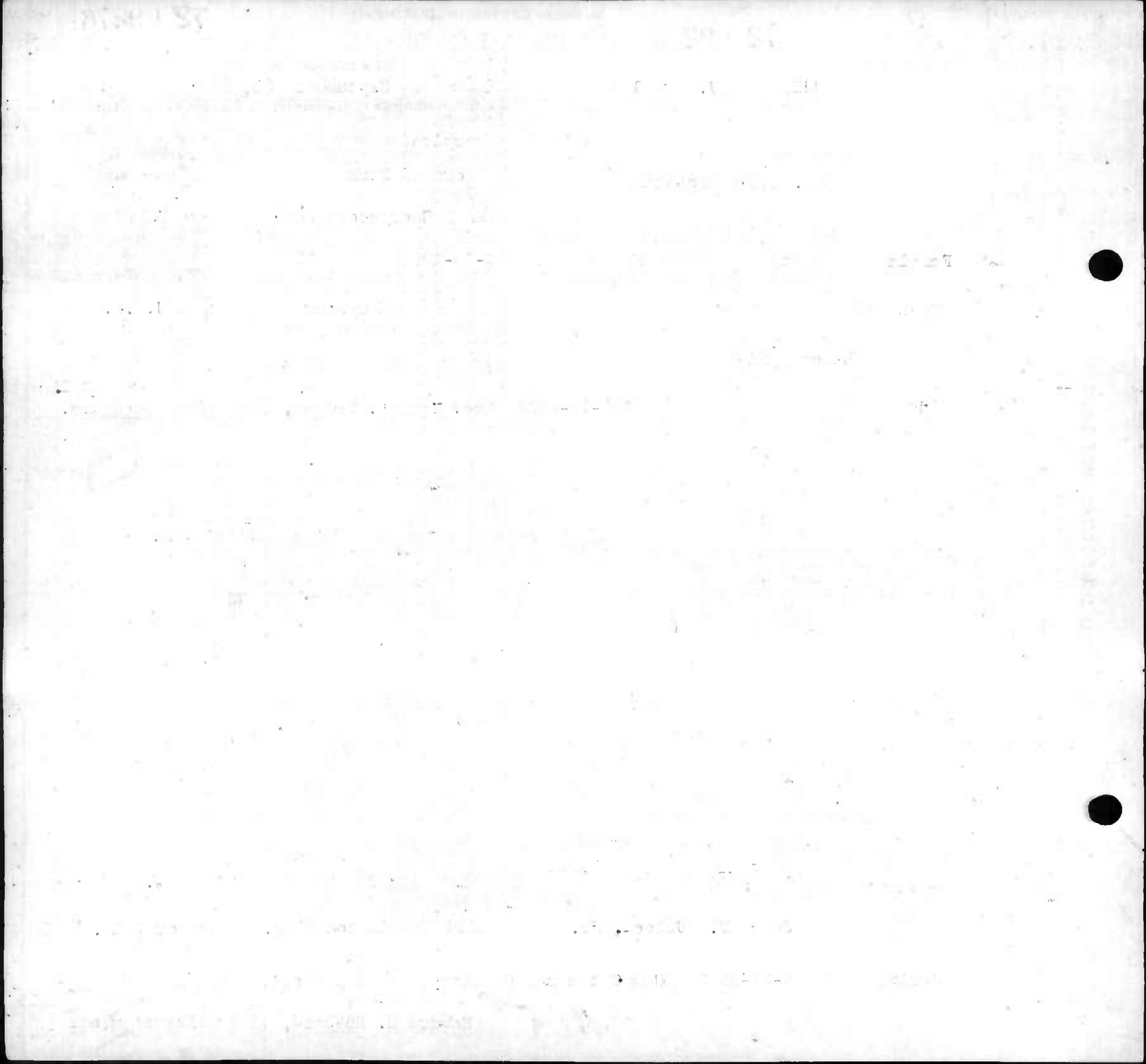
A-536		72 09275		BALTIMORE CITY HEALTH DEPARTMENT		72 09275	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Anderson, Wiggo K., SR.				September 23, 1972 9:35 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE ANNOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
90 Harbor View Nursing Home 1213 Light St				Md. 1207			
5. SEX				6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
M.				White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Ret.				Md. Drydock		April 16, 1894	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME		9. AGE (In years last birthday)	
Unknown				Unknown		78	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
No				100-09-1517		ADDRESS 21227 Wiggo K. Anderson, Jr. 4761 Belwood Green	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				Carcinoma of Lung -			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) A.S.C.V.W.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(C)			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? Yes or No	
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? Yes or No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/25 19 72 to 9/23 19 72				that (I) (we) last saw the deceased alive on 9/23 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
Joseph S. Blum M.D.				9/26/72		1115 N. CALVERT ST	
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME of CEMETERY or CREMATORY	
CREMATION				9-27-72		Loudon Park Crematory	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
SEP 28 1972				Sidney H. Wilson		ADDRESS Howard H. Hubbard Funeral Home 2107 Wilkens Aven.	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09276	
72 09276				STATE OF MARYLAND-DEATH	
BIRTH NO. M-200		72 09276		72 09276	
1. NAME OF DECEASED (Type or Print) ANNIE V. MC GEE		2. DATE AND HOUR OF DEATH September 24, 1972 7 A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 St. Agnes Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2582 C. CITY OR TOWN Morrell Park D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2803 Georgetown Road 21230			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-18-1890	9. AGE (In years last birthday) 82	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME LeRoy Kidd		14. MOTHER'S MAIDEN NAME Anna Mitten	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-74-5216		17. INFORMANT ADDRESS 21230 Mrs. Mary E. Poling, 1733 Wilmington Ave.	
18. 250.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocarditis (B) Anteroseptal Heart Disease (C) Diabetes Mellitus		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 2 years 12 years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/18 1965 to 9/24 1972, that (I) (we) last saw the deceased alive on 9-22 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John P. Urlock, Jr.		23B. DATE SIGNED 9/25/72		23C. PHYSICIAN'S NAME (Type) John P. Urlock, Jr.	
23D. ADDRESS 1227 Washington Blvd., Baltimore, Md. 21230		23E. DATE REC'D BY HEALTH DEPT. SEP 28 1972		23F. NAME OF REGISTRAR Howard H. Hubbard	
23G. DATE REC'D BY HEALTH DEPT. SEP 28 1972		23H. NAME OF REGISTRAR Howard H. Hubbard		23I. FUNERAL DIRECTOR ADDRESS 21229	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-27-1972		24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Maryland		24E. LOCATION (State) Maryland		24F. LOCATION (State) Maryland	



1		W-300		72 09277		BALTIMORE CITY HEALTH DEPARTMENT		X 72 09277	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH						REG. NO.			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		Pearline SANDRA WHITE		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year September 21, 1972	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (If not in hospital or institution, give street address or location)		33 JOHNS HOPKINS HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year September 21, 1972		10:15 P.M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
6. SEX Female		7. RACE Negro		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Annapolis		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 2-23-1948		10. AGE (In years last birthday) 24		If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER 10 Roosevelt Drive			
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas Eugene Harried, Sr		14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurses Aid		14B. KIND OF BUSINESS OR INDUSTRY Crownsville St Hospt	
15. MOTHER'S MAIDEN NAME Irene Virginia Tongue		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 217-52-1908		18. INFORMANT Mrs Thomas Harried 10 Roosevelt Drive, Anna, Md		ADDRESS	
19. 347.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH Hemoptysis and aspiration of blood (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Erosion of tracheostomy tube into left common carotid artery (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Cerebral anoxia (Etiology undetermined)		21. AUTOPSY? (Yes or No) yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9/22/72	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-26-1972		24C. NAME of CEMETERY or CREMATORY Chews Memorial		24D. LOCATION (City, town, or county) (State) Anne Arundel Md	
25A. DATE REC'D BY HEALTH DEPT. SEP 28 1972		25B. NAME OF REGISTRAR A. J. [Signature]		25C. FUNERAL DIRECTOR C. P. Hicks		111 1922 Forest Drive, Anna, Md		ADDRESS	



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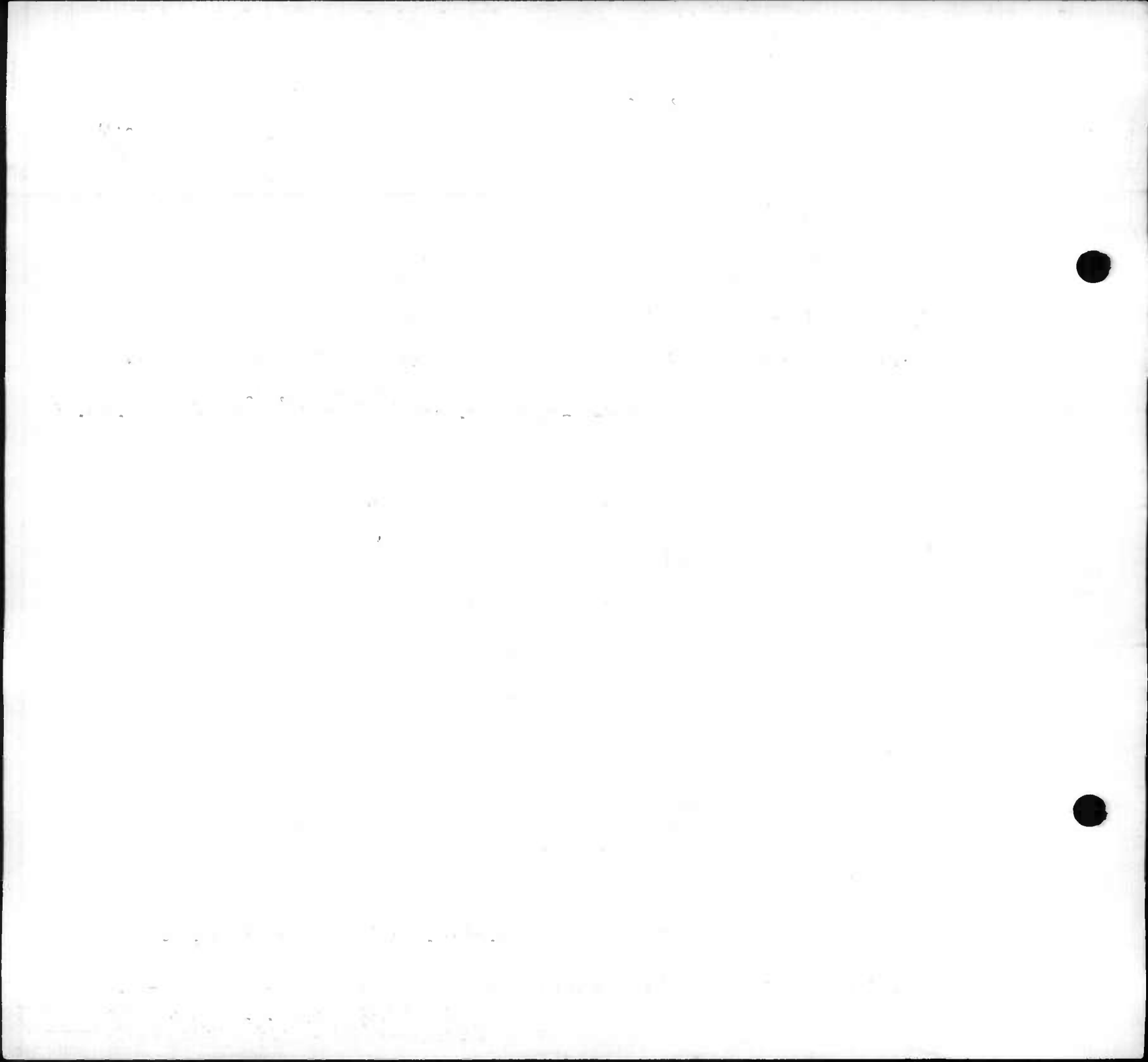
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 72 09278	
BIRTH NO. <span style="font-size: 1.5em;">T-632</span> <span style="font-size: 1.5em;">72 09278</span>							
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Ray</span> <span style="font-size: 1.2em;">Harold Hritch, Sr.</span>				2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">9/26/72</span> <span style="font-size: 1.2em;">12:45 A.M.</span>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">University of Maryland Hospital</span>				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">WASH.</span> C. CITY OR TOWN <span style="font-size: 1.2em;">Hagerstown</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.2em;">1017 Fairview Road</span>			
5. SEX <span style="font-size: 1.2em;">m</span>	6. RACE <span style="font-size: 1.2em;">w</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">3/13/03</span>	9. AGE (in years last birthday) <span style="font-size: 1.2em;">69</span>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Rail Road Engineer</span>			10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Rail Road</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>		
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>			13. FATHER'S NAME <span style="font-size: 1.2em;">Walter Henry Hritch</span>				
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Mary Elizabeth Brewer</span>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>				
16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">705-10-5216</span>			17. INFORMANT <span style="font-size: 1.2em;">Hagerstown, Md.</span> ADDRESS <span style="font-size: 1.2em;">Mrs. Rosella Mowen 1600 Oak Hill Ave. Apt. 5</span>				
18. CAUSE OF DEATH <span style="font-size: 1.5em;">I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <span style="font-size: 1.2em;">Pneumonia</span> DUE TO, OR AS A CONSEQUENCE OF: (B) <span style="font-size: 1.2em;">Pneumonia</span> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <span style="font-size: 1.2em;">prob. (L) Hemiplegic CVA</span>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">2-3 weeks</span>			
19A. DATE OF OPERATION <span style="font-size: 1.2em;">9/26/72</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">NO</span>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <span style="font-size: 1.2em;">9/13</span> 19 <span style="font-size: 1.2em;">72</span> to <span style="font-size: 1.2em;">9/26</span> 19 <span style="font-size: 1.2em;">72</span> that (2) (we) last saw the deceased alive on <span style="font-size: 1.2em;">9/25</span> 19 <span style="font-size: 1.2em;">72</span> and that (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <span style="font-size: 1.2em;">Richard A. Tomasulo</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">9/26</span>			
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Richard Tomasulo</span>				23D. ADDRESS <span style="font-size: 1.2em;">U. of Md. Hospital Baltimore, Md.</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">9/28/72</span>		24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Rest Haven Cemetery</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Hagerstown-Washington-Md.</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">SEP 28 1972</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">William A. Hart</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">William A. Hart</span>			



S-536

72 09279

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 09279

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>AMEL SNYDER</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>33 Johns Hopkins Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>9 25 1972 8:18 p</b> M.	
6. SEX <b>male</b>		7. RACE <b>white</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>10/8/18</b>		10. AGE (In years last birthday) <b>53</b>	
11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Snyder</b>		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>601</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Custodian School</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Baltimore County</b>	
15. MOTHER'S MAIDEN NAME <b>Ann Yerich</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes WW 2</b>	
17. SOCIAL SECURITY NO. <b>217-14-6630</b>		18. INFORMANT <b>Taneytown, Md. Mrs. Edward Snyder Box 200 Rfd 1</b>	
19. CAUSE OF DEATH <b>162.1 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of lung</b> <b>II. ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>162.1</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>no</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>R. S. Fisher</b> EXAMINER'S NAME (Type)		M.D. <b>Russell S. Fisher, M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/28/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Gettysburg National Cemetery, Penna.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md. 21224</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 28 1972</b>		25B. NAME OF REGISTRAR <b>Anthony W. Brown</b>	
25C. FUNERAL DIRECTOR <b>John A. Moran, Inc.</b>		ADDRESS <b>3000 E. Baltimore St.</b>	

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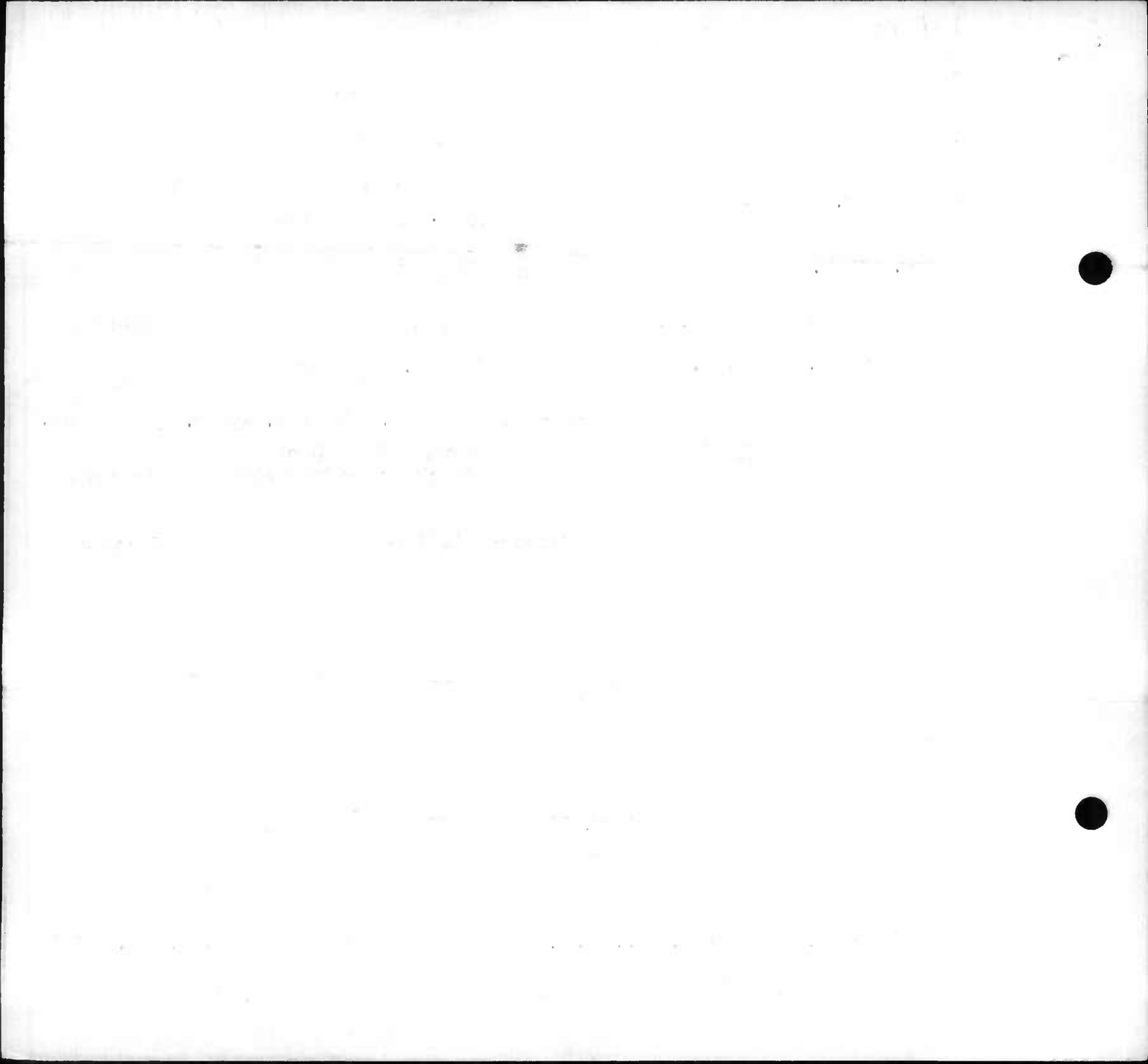
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				72 69280 REG. NO. _____	
BIRTH NO. <u>W-420</u>		72 69280			
1. NAME OF DECEASED (Type or Print) <u>Owen Patrick Wills</u>			2. DATE AND HOUR OF DEATH <u>September 25, 1972</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>102</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00 237 S. Ellwood Avenue</u>			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>237 S. Ellwood Avenue</u>		
5. SEX <u>M.</u>	6. RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>10/31/'20</u>	9. AGE (In years last birthday) <u>51</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>City Inspector Dept. Sanitation</u>			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Frank J. Wills, Sr.</u>			14. MOTHER'S MAIDEN NAME <u>Mary C. Reynolds</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>217-18-9586</u>	17. INFORMANT <u>Frank J. Wills, Jr.</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>217-18-9586</u>	ADDRESS <u>237 S. Ellwood Ave.</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>metastasis to liver</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last <u>Carcinoma of lung with</u> <u>Diabetes Mellitus</u>			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Carcinoma of lung with</u> (B) <u>Diabetes Mellitus</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u> <u>2 years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>9/29/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>1 + 250.9</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>metastasis to liver</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Sept. 21</u> 19 <u>72</u> to <u>Sept. 21</u> 19 <u>72</u> and that (I) (we) last saw the deceased alive on <u>Sept. 21</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>W. H. Townsend M.D.</u>			23B. DATE SIGNED <u>9-26-72</u>		
23C. PHYSICIAN'S NAME (Type) <u>Wilfred H. Townshend, Jr., M.D.</u>			23D. ADDRESS <u>14 East Eager Street - Balto. Md. 21202</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>9/29/72</u>	24C. NAME of CEMETERY or CREMATORY <u>Most Holy Redeemer Cemetery, Baltimore, Maryland</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 28 1972</u>		25B. NAME OF REGISTRAR <u>Adrian Johnson</u>		25C. FUNERAL DIRECTOR <u>3000 E. Baltimore St. Baltimore, Md. 21224</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 09281</b>	
7-422 72 09281				STATE OF MARYLAND - DIME	
1. NAME OF DECEASED (Type or Print) <b>FOWLKES, JOSEPH</b>			2. DATE AND HOUR OF DEATH <b>9/26/72 6:40 pm</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>33</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>JOHNS HOPKINS HOSPITAL 601 N. BROADWAY</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>807</b>		
5. SEX <b>M</b>			6. RACE <b>B</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED LABORER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>BETHELM STEEL</b>		9. AGE (In years last birthday) <b>48</b> If Under 1 Yr. Months: <b>11</b> Days: <b>29</b> If Under 24 Hrs. Hours: <b>29</b> Min.	
11. BIRTHPLACE (State or foreign country) <b>CREW, V.A.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>CHRISTOPHER FOWLKES</b>			14. MOTHER'S MAIDEN NAME <b>JENNINGS, NANNIE</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES W.W.II 1/3/44</b>		16. SOCIAL SECURITY NO. <b>229 14 3134</b>		17. INFORMANT <b>RUTH FOWLKES</b> ADDRESS <b>1705 E. OLIVER ST. BALT. MD.</b>	
18. <b>2309 I 10/24/45</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH <b>Prior cerebral ischemia</b> (A) IMMEDIATE CAUSE <b>due to cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Seizure activity</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Diabetes mellitus, Kimmelstiel Wilson</b>		
19A. DATE OF OPERATION <b>10/24/45</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>II</b>		
20A. AUTOPSY? (Yes or No) <b>NO</b>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>September 22</u> 19 <u>72</u> to <u>September 26</u> 19 <u>72</u> , that (I) <u>(we)</u> lost saw the deceased alive on <u>September 26</u> 19 <u>72</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <b>Joel Moss</b> MD DEGREE			23B. DATE SIGNED <b>September 26, 1972</b>		
23C. PHYSICIAN'S NAME (Type) <b>JOEL Moss</b> MD DEGREE			23D. ADDRESS <b>Johns Hopkins Hospital</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>9/30/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>MT. AUBURN CEMETARY</b>	
24D. LOCATION (City, town, or county) (State) <b>MT. WINNANS WEST PORT BALT. MD.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 28 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Winston</b>		25C. FUNERAL DIRECTOR <b>WILLIAM J. SPICER</b> ADDRESS <b>1639 N. BROADWAY BALT. MD.</b>	

[Faint, mostly illegible text covering the majority of the page, likely bleed-through from the reverse side. Some faint words like "STANDARD FORM NO. 64" and "OFFICE OF THE SECRETARY OF DEFENSE" are visible.]



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 09282

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO. 72 09282

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)(LELIA B. McCRAW)  
Lelia McGraw (McCRAW)

2. DATE AND HOUR OF DEATH

9-24-1972

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)31 Baltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Md. 212244. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE 8. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

6214 Copore Way

21224

5. SEX

Female

6. RACE

Caucasian

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

Feb. 24-09

9. AGE (In years  
last birthday)

63

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

West Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Frank Beckett

14. MOTHER'S MAIDEN NAME

Unknown

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

214-22-6357

17. INFORMANT

ADDRESS

Records: BCH-4940 Eastern Ave. 21224

18. 41241

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:(B) ASCVD  
DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

basilar artery occlusion 9 months

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

No left middle cerebral artery occlusion

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (Notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-17 1972 to 9-24 1972  
that (I) (we) last saw the deceased alive on 9-24 1972 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Herbert G. Markley M.D.  
Herbert G. MarkleyAttending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

9-24-72

23C. PHYSICIAN'S  
NAME (Type)

23D. ADDRESS

Baltimore City Hospitals

DEGREE

4940 Eastern Ave., Baltimore, Md. 21224

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

9-28-72

24C. NAME of CEMETERY or CREMATORY

St. Stanislaus Cem

24D. LOCATION

(City, town, or county)

(State)

6515 Boston Ave., Balto., Md.

25A. DATE REC'D BY HEALTH DEPT.

SEP 28 1972

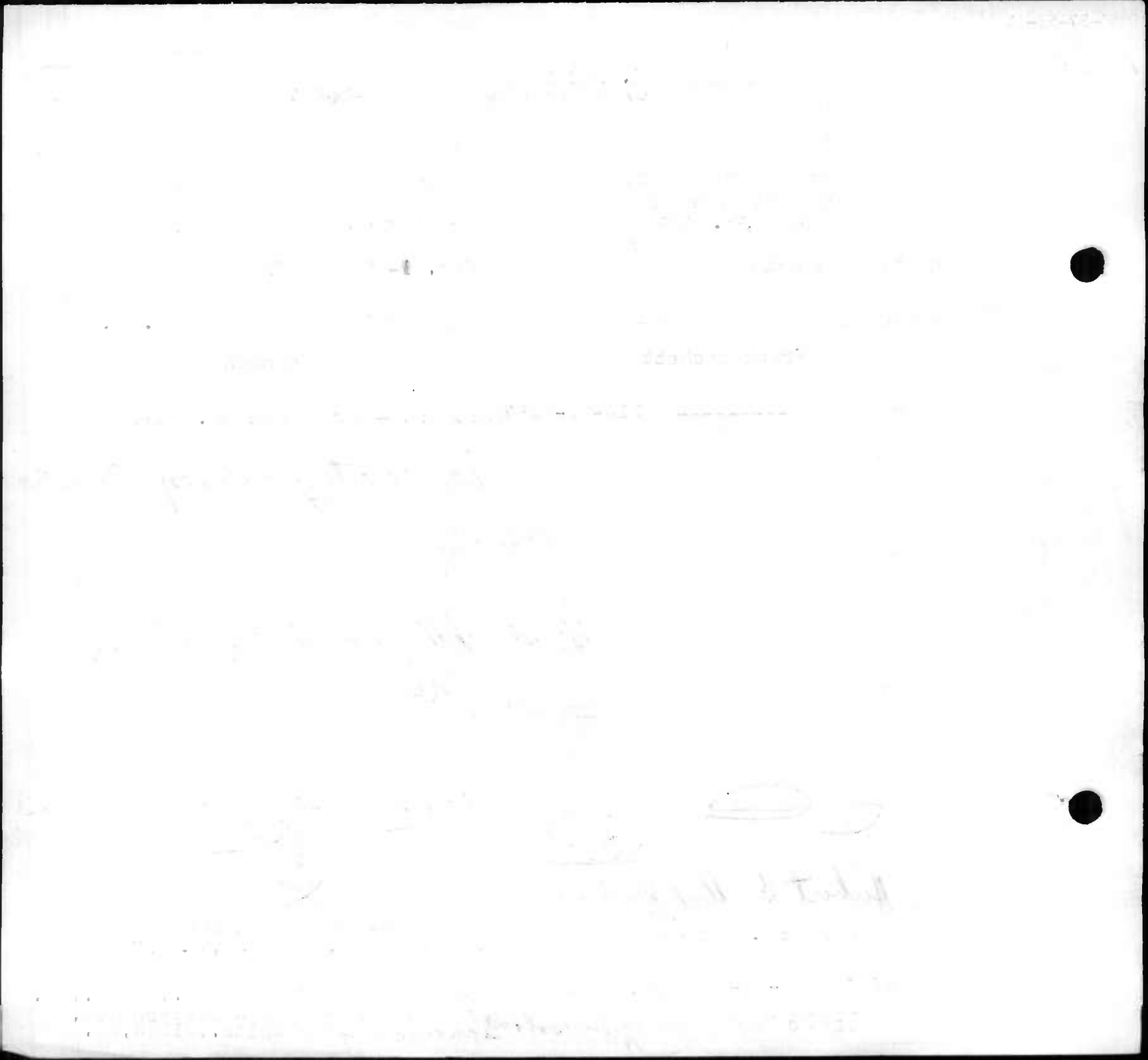
25B. NAME OF REGISTRAR

Sidney H. Boston

25C. FUNERAL DIRECTOR

Charles J. Ziller

6224 Eastern Ave.  
Balto., 21224, Md.



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 09283

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

JOSEPH Patrick Cosgrove

2. DATE OF DEATH

Known ☒ Estimated ☐

Month

Day

Year

Hour

9

19

72

3:45 A. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 Police Impounding Lot  
200 blk. Harrison St.

3. DATE PRONOUNCED DEAD

Month

Day

Year

Hour

9

19

72

3:45 A. M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

302

6. SEX

Male

7. RACE

White

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

9-7-39

10. AGE (in years last birthday)

33

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

5 N. Exeter St.

11. BIRTHPLACE (State or foreign country)

N.Y.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

COSGROVE

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

MARGARET BRODY

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

YES

17. SOCIAL SECURITY NO.

127 30 5804

18. INFORMANT

ADDRESS

HAROLD LUX 812 OREGON DR.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

Multiple

(A) IMMEDIATE CAUSE / Stabwounds of chest  
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?

200 blk Harrison St.

22D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

9

19

72

3:00A

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

found stabbed

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S

NAME (Type)

William P. Mulloy, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9-19-72

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county)

(State)

BURIAL

9-27-72

SACRED HEART OF JESUS DUNDALK

MD

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

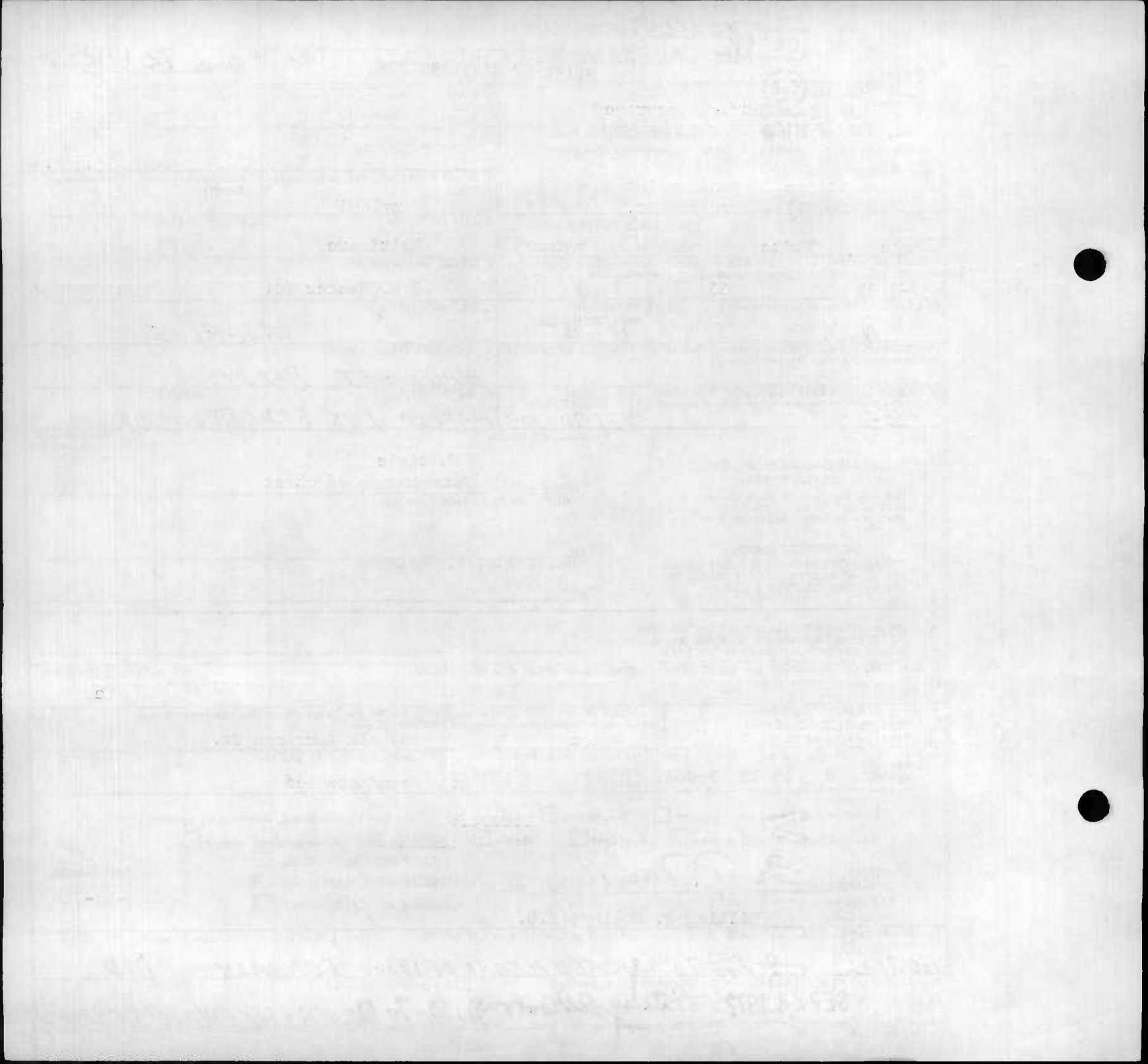
25C. FUNERAL DIRECTOR

ADDRESS

SEP 28 1972

Sidney W. Heston

JOHN M. DEBER &amp; SONS INC. HOLLS CHESTER

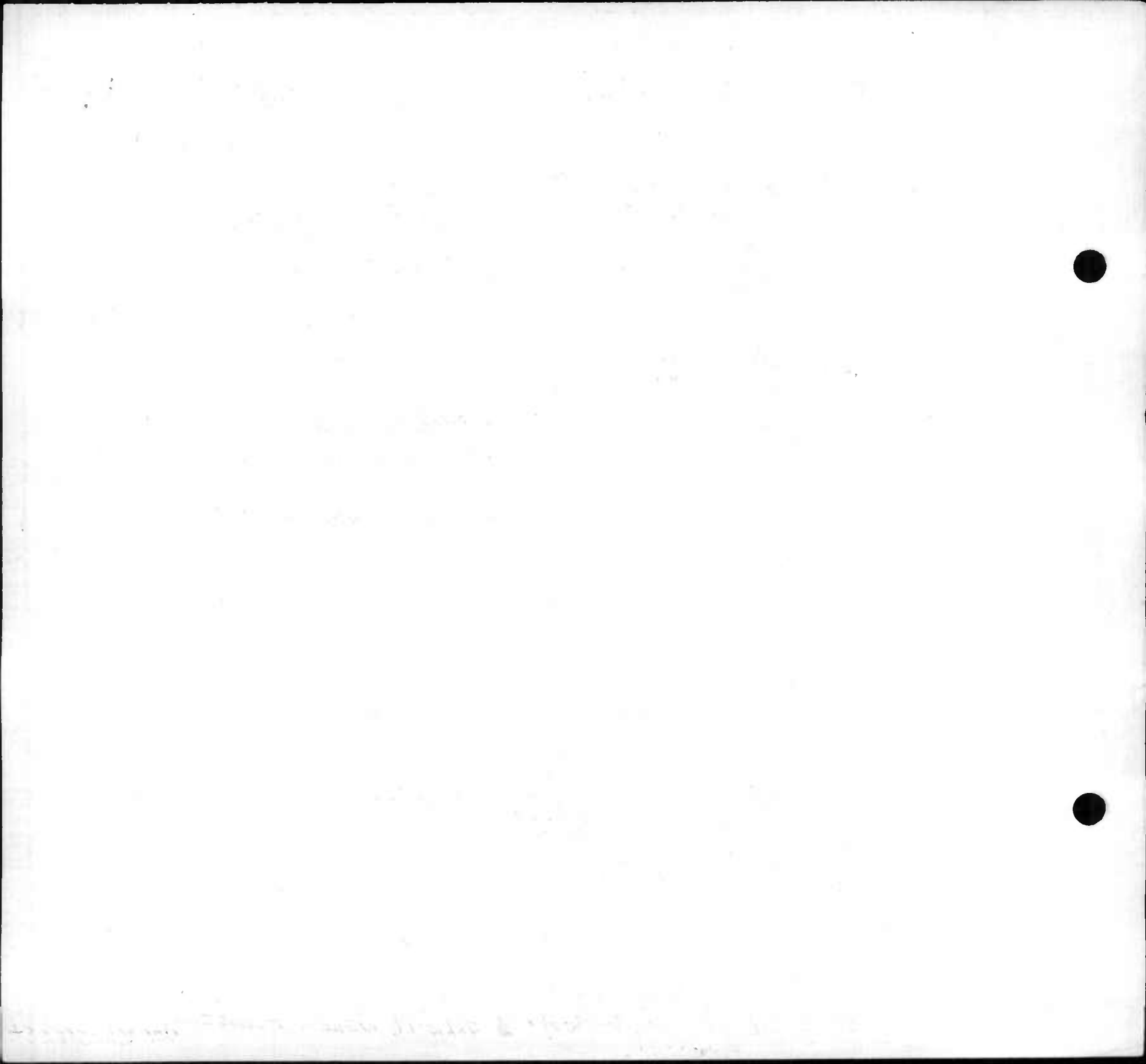


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 09284 BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

REG. NO. 72 09284  
 STATE OF MARYLAND-DEATH

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>WOJCIECHOWSKI ALEXANDER</b>		2. DATE AND HOUR OF DEATH <b>9/26/72 9:45 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Church Home &amp; Hospital 100 North Broadway</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>City</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>M</b>		6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>3-21-1877</b>		9. AGE (In years last birthday) <b>95</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN</b>		13. FATHER'S NAME <b>Unknown</b>	
14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-09-8191</b>	
17. INFORMANT <b>LILLIAN DEMARCO</b>		ADDRESS		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute Pulmonary Edema</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Chronic Heart Failure</b>	
19. DATE OF OPERATION <b>9/27/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <b>9/25/72</b> to <b>9/25/72</b> 19 <b>72</b> and that (I) (we) lost saw the deceased alive on <b>9/25/72</b> 19 <b>72</b> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <b>Walker A. Impagliati</b>	
23B. DATE SIGNED <b>9-26-72</b>		23C. PHYSICIAN'S NAME (Type) <b>WALKER A. IMPAGLIATELLI</b>		23D. ADDRESS <b>Church Home &amp; Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>9-30-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>HOLY ROSARY CEMETERY</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MD.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 28 1972</b>		25B. NAME OF REGISTRAR <b>Andrew M. Weber</b>	
25C. FUNERAL DIRECTOR <b>John M. Weber &amp; Son's Inc.</b>		ADDRESS <b>401 CHESTER ST.</b>			

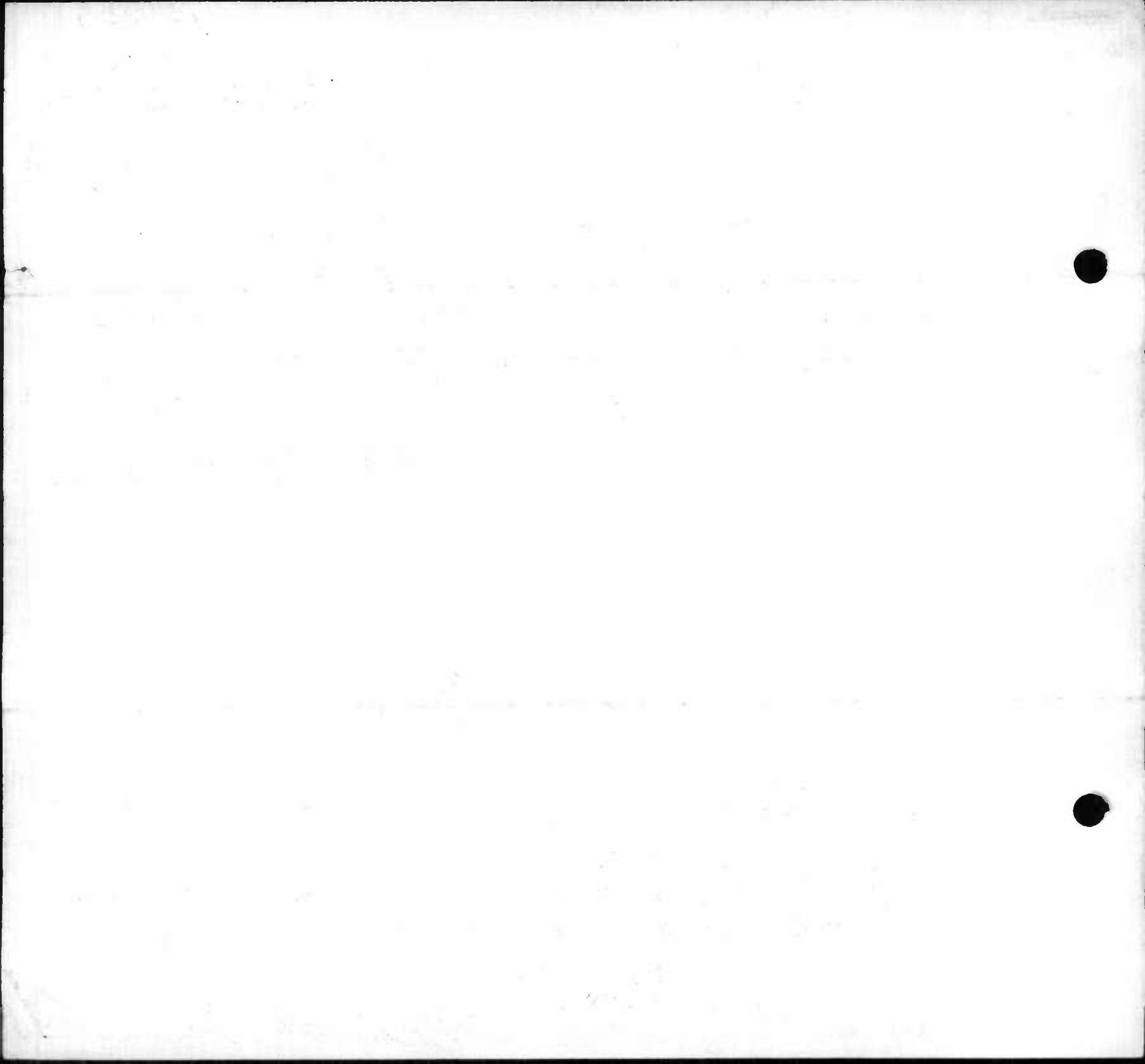


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 09285		72 09285	
BIRTH NO.		72 09285		72 09285	
1. NAME OF DECEASED (Type or Print) <u>ZUREL, MARIA</u>		2. DATE AND HOUR OF DEATH <u>9/25/72</u> <u>12</u> <u>38</u> <u>A.</u> <u>M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>91 MONTEBELLO STATE HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MARYLAND - BALTIMORE COUNTY</u> B. COUNTY <u>5300</u> C. CITY OR TOWN <u></u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>3055 ESSEX ROAD</u> <u>21207</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-10-1919</u>	9. AGE (In years last birthday) <u>55</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>HOLLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>HOLLAND</u>		13. FATHER'S NAME <u>JOSEPHUS PETRUS ELSTHOUT</u>		14. MOTHER'S MAIDEN NAME <u>Adriana J. Chauden</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>PATIENT'S CHART</u> ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>43291</u> <u>BASILAR ARTERY THROMBOSIS</u> <u>(A) IMMEDIATE CAUSE 2 DEFERENT SYNDROME</u> DUE TO, OR AS A CONSEQUENCE OF: <u>9 MOS.</u>		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>5/23/72</u> to <u>9/25/72</u> that (1) (we) last saw the deceased alive on <u>9/24/72</u> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>J. K. Marshall, Jr. M.D.</u>		23B. DATE SIGNED <u>9/25/72</u>			
23C. PHYSICIAN'S NAME (Type) <u>J. K. MARSHALL, JR. M.D.</u>		23D. ADDRESS <u>MONTEBELLO STATE HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/27/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt Olivet</u>	
24D. LOCATION (City, town, or county) (State) <u>Hamover Pa York Co</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 28 1972</u>		25B. NAME OF FUNERAL DIRECTOR <u>Lidney Johnson</u>		25C. FUNERAL DIRECTOR ADDRESS <u>W. K. Semerly Hamover Pa</u>	

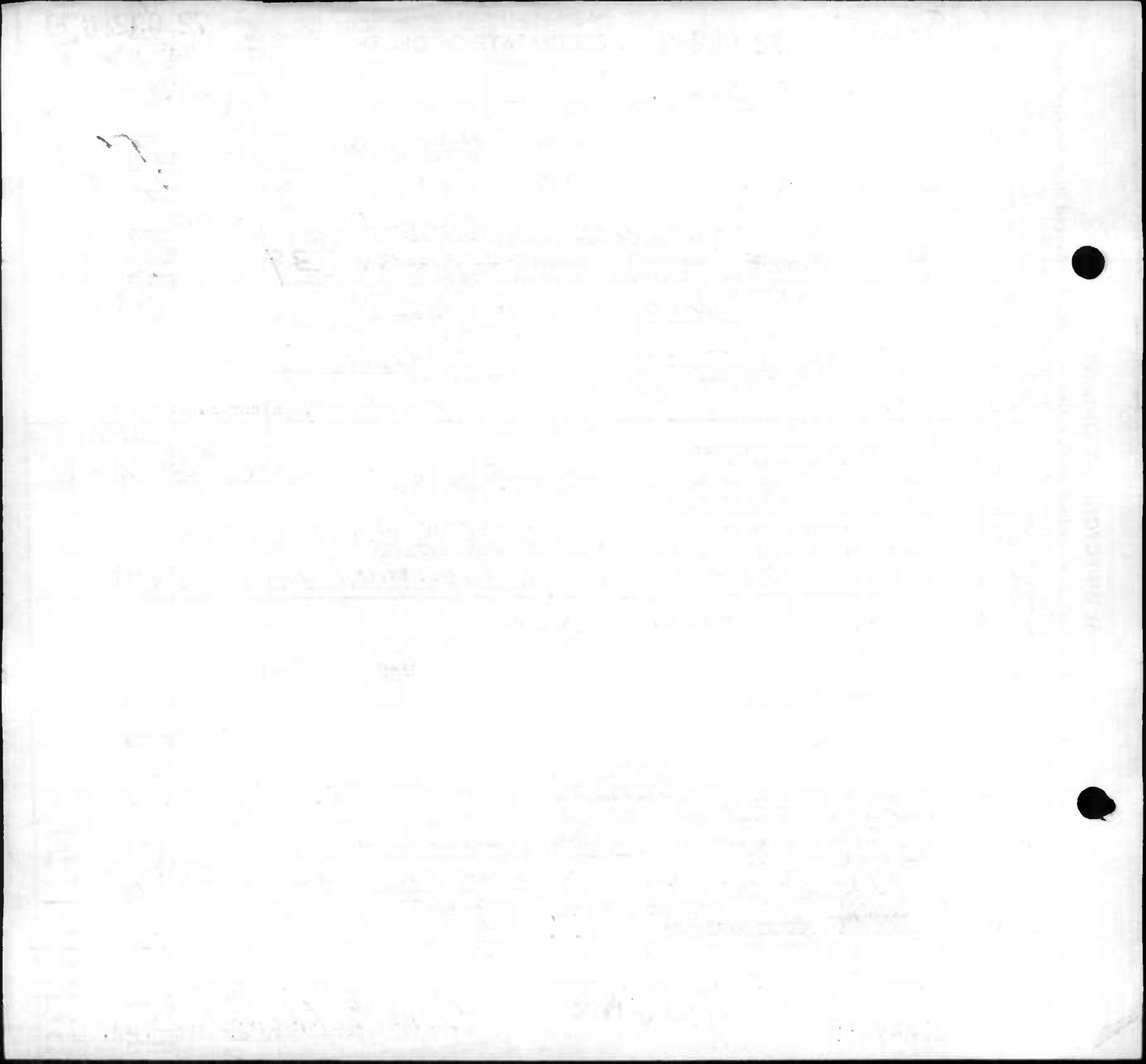




# FUNERAL DIRECTOR: IMPORTANT

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S-625		72 09286		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09286	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Sargent Rita M.</u>				2. DATE AND HOUR OF DEATH <u>9/23/72 9:00 PM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Cecil</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Johns Hopkins Hospital</u>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN <u>ELKTON</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>F</u>		6. RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/14/34</u>	
9. AGE (In years last birthday) <u>37</u>		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>CASTING INDUSTRY</u>		11. BIRTHPLACE (State or foreign country) <u>ALBANY, N.Y.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>CHARLES BOSLEY</u>		14. MOTHER'S MAIDEN NAME <u>FARRELL, IDA</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Husband, Walter J. Sargent</u>		ADDRESS			
18. <u>395-01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <u>ACUTE BACTERIAL ENDOCARDITIS</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>PROSTHETIC AORTIC VALVE</u>			
				(B) DUE TO, OR AS A CONSEQUENCE OF: <u>FOR RHEUMATIC HEART DISEASE</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>NONE</u>							
19A. DATE OF OPERATION <u>22</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTAIN CAUSES OF DEATH? <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>SEPT 20</u> 19 <u>72</u> to <u>SEPT 23</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>SEPT 23</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Ernest Arnett M.D.</u>				23B. DATE SIGNED <u>9/23/72</u>		23C. PHYSICIAN'S NAME (Typed) <u>XXXXXXXXXXXXXXXXXXXX</u> M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/27/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Gilpin Manor Memorial Park</u>		24D. LOCATION (City, town, or county) (State) <u>Elkton, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 28 1972</u>		25B. NAME OF FUNERAL HOME <u>Harvey E. Hicks</u>		25C. FUNERAL DIRECTOR <u>Harvey E. Hicks</u>		ADDRESS <u>Hicks Home for Funerals, Elkton, Md.</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/68

75000 55

RECEIVED BY THE OFFICE OF THE ATTORNEY GENERAL

10-2-55

STATE OF NEW YORK  
IN SENATE  
JANUARY 13, 1955

REPORT OF THE

COMMISSIONER OF THE DEPARTMENT OF CORRECTIONS

FOR THE YEAR 1954

ALBANY, NEW YORK

1955

WILLIAM W. WATSON

GOVERNOR

ALBANY, NEW YORK

1955

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GOVERNOR

ALBANY, NEW YORK

1955

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ALBANY, NEW YORK

1955

WILLIAM W. WATSON

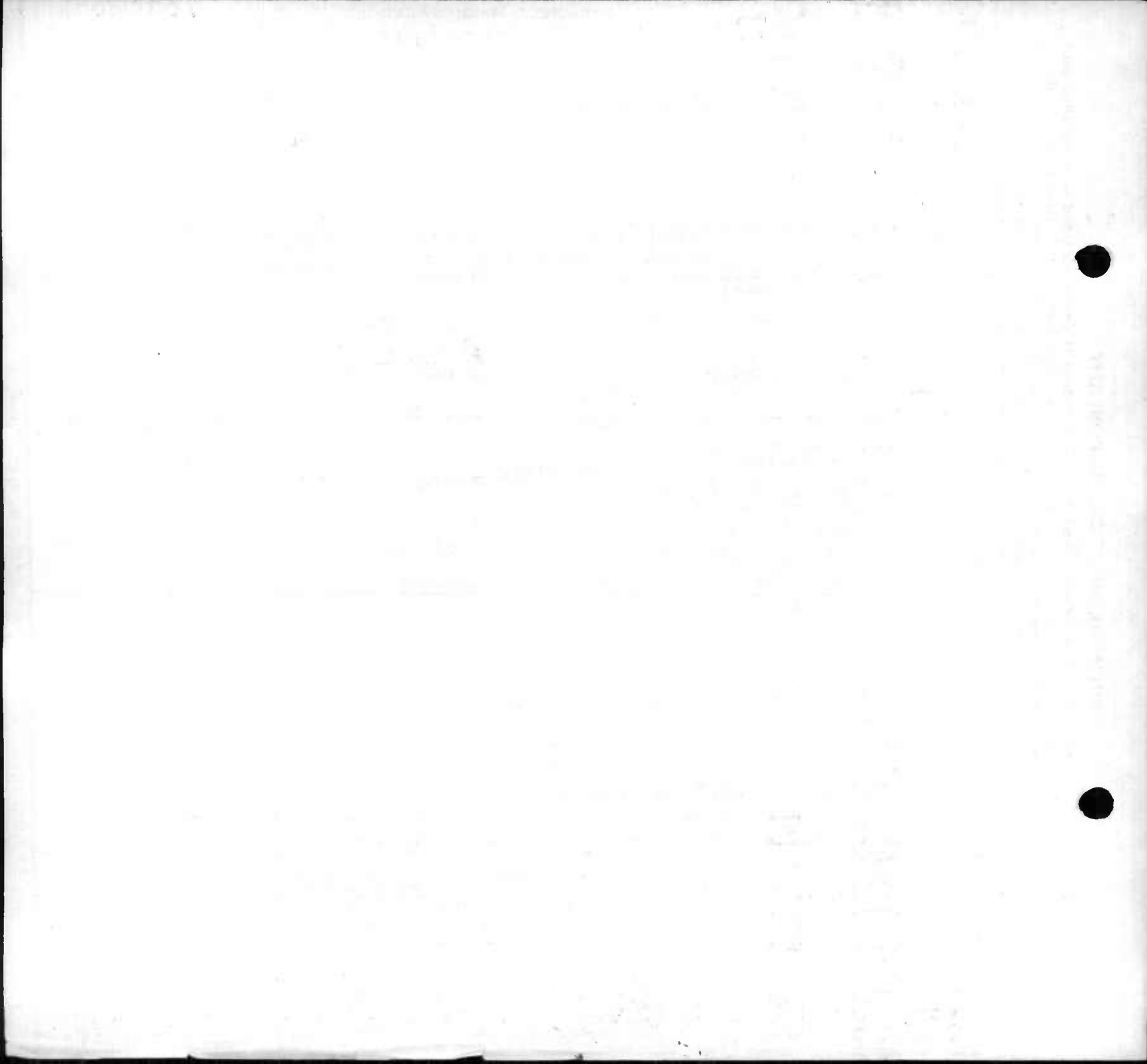
GOVERNOR

75000 55

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-650		72 09288		BALTIMORE CITY HEALTH DEPARTMENT		72 09288	
CERTIFICATE OF DEATH				REG. NO. _____			
1. NAME OF DECEASED (Type or Print) <b>ROBERT BROWN</b>				2. DATE AND HOUR OF DEATH <b>9/27/72</b> <b>1:40 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1605</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Provident Hospital, Balto, Md.</b> <b>39</b>				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>1105 N. Bentalow ST</b>			
5. SEX <b>M</b>	6. RACE <b>B</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-25-1875</b>	9. AGE (In years last birthday) <b>96</b>	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Joe Brown</b>			
14. MOTHER'S MAIDEN NAME <b>Adeline (Brown) Dunlap</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b>			
16. SOCIAL SECURITY NO. <b>24834-6500</b>				17. INFORMANT <b>Mrs. Sellig Watkins</b>			
18. <b>682.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Suspected Pulmonary Embolism</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>less than 30 min</b>				19. <b>Cellulitis of Right Leg</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>3 weeks</b>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(C)</b>				20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
21A. DATE OF OPERATION <b>NONE</b>		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR?		21D. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Sept. 11, 1972</b> to <b>Sept. 27, 1972</b> that (I) (we) lost saw the deceased alive on <b>Sept 27, 1972</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Rodolfo Quion M.D.</b>				23B. DATE SIGNED <b>9-27-72</b>		23C. PHYSICIAN'S NAME (Type) <b>Rodolfo Quion M.D.</b>	
23D. ADDRESS <b>Provident Hospital Balto. Md.</b>				23E. FUNERAL DIRECTOR <b>Arlington S. Phillips</b>		23F. ADDRESS <b>1727 N. Monroe St.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-30-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 28 1972</b>		25B. NAME OF REGISTRAR <b>Arbutus Mem. Park</b>		25C. FUNERAL DIRECTOR <b>Arlington S. Phillips</b>		25D. ADDRESS <b>1727 N. Monroe St.</b>	





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 09289

BIRTH NO.

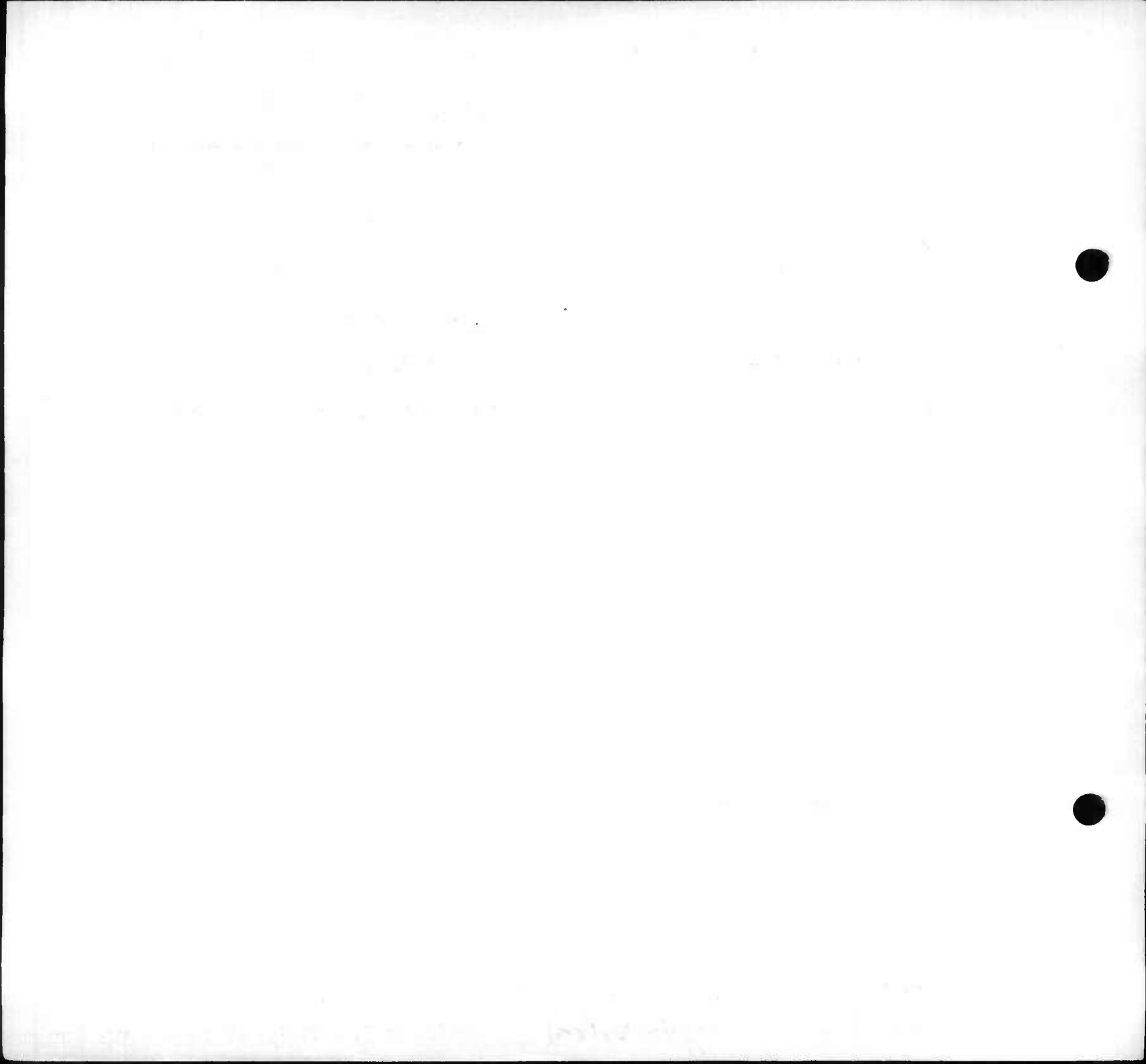
1. NAME OF DECEASED (Type or Print) <b>CLYDE PARMELY</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>September 24, 1972</b>		Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>4534 Pilmico Road</b> <i>1-9-73</i>		3. DATE PRONOUNCED DEAD Month Day Year <b>September 24, 1972</b>		Hour <b>3:45 A.</b>	
5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) A. STATE <b>Maryland</b>		B. COUNTY <b>2716</b>			
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
9. DATE OF BIRTH <b>Feb. 14, 1922</b>		10. AGE (In years last birthday) <b>50</b>		11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Dock Parmely</b>		14. MOTHER'S MAIDEN NAME <b>Blanche Woodberry</b>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		16. KIND OF BUSINESS OR INDUSTRY		17. SOCIAL SECURITY NO. <b>213-28-6145</b>	
18. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b>		19. INFORMANT <b>Mrs. Dorothy Parmely</b> ADDRESS <b>4534 Pilmico Road</b>			
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE <b>Gunshot wound of head</b> DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>Yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>4534 Pilmico Road</b> <i>27-16</i>	
22D. TIME OF INJURY (APPROX.) <b>9-24-72 3:40 A. m.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Shot by assailant</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> <u>Undetermined manner</u> <input checked="" type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Marvin S. Platt, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>September 24, 1972</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-27-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Maryland National</b>	
24D. LOCATION (City, town, or county) (State) <b>Laurel, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 28 1972</b>			
25B. NAME OF REGISTRAR <b>Arlington S. Phillips</b>		25C. FUNERAL DIRECTOR <b>Arlington S. Phillips</b> ADDRESS <b>1727 N. Monroe Street</b>			

1-9-1973 - Letter from the Office of the Chief Medical Examiner - Marvin S. Platt, M.D.,  
Assistant Medical Examiner hs

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09290		REG. NO. 72 09290	
W-463 72 09290				CERTIFICATE OF DEATH		STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print) <u>William Willard</u>				2. DATE AND HOUR OF DEATH <u>9/25/72 1:47 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Sinai Hospital of Baltimore, Inc.</u> <u>Belvedere &amp; Greenspring AVE.</u> <u>Baltimore, Maryland, 21215</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore, Md.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3215 Westwood Avenue 1506</u>			
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/10/06</u>		9. AGE (In years last birthday) <u>66</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired.</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Nathaniel Willard</u>				14. MOTHER'S MAIDEN NAME <u>Annie Goldbolt</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-03-4870A</u>		17. INFORMANT <u>Mrs. Lelia Willard</u>		ADDRESS <u>3215 Westwood Avenue</u>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(A) IMMEDIATE CAUSE <u>Carcinoma of Lung</u> DUE TO, OR AS A CONSEQUENCE OF:  (B) <u>Smoking Cigarettes</u> DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6-10 months</u>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <u>(at this hospital)</u> attended the deceased from <u>9/17</u> 19 <u>72</u> to <u>9/25</u> 19 <u>72</u> that (I) <u>(we)</u> last saw the deceased alive on <u>9/25</u> 19 <u>72</u> and that in <u>(my)</u> <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> (did) (did not) view the body after death.							
23A. SIGNATURE <u>Robert Kroppnick M.D.</u> DEGREE				23B. DATE SIGNED <u>9/25/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Robert Kroppnick M.D.</u>	
23D. ADDRESS <u>9008 Meadowcroft Road, Randall</u> DEGREE							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-29-72</u>		24C. NAME of CEMETERY or CREMATORY <u>Arbutus Mem. Park</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 28 1972</u>				25B. NAME OF REGISTRAR <u>Arbutus Mem. Park</u>		25C. FUNERAL DIRECTOR <u>Arlington S. Phillips</u> ADDRESS <u>1727 N. Monroe Street</u>	



1

P-630 72 69291 STATE OF MARYLAND-DEMD BALTIMORE CITY HEALTH DEPARTMENT

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 69291 REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>DAVID PARROTT</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 1818 N. Chester Street</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>September 27, 1972 5:14 A.</b> M.	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>3-25-09</b>		10. AGE (In years last birthday) <b>63</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Samuel Parrott</b>		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>806</b>	
15. STREET AND NUMBER <b>1818 N. Chester Street</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>James Chisholm</b>		ADDRESS <b>1818 N. Chester Street</b>	
19. <b>4124</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>no</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>9/27/72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-2-72</b>	
24C. NAME of CEMETERY or CREMATORY <b>Baltimore Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 28 1972</b>		25B. NAME OF REGISTRAR <b>William C. March</b>	
25C. FUNERAL DIRECTOR <b>William C. March</b>		ADDRESS <b>928 E North Ave.</b>	

VS 151-REV. 1/1/68

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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09292		72 09292	
BIRTH NO. C-240				72 09292			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
<b>CHISLEY, Olie (Olley)</b>				<b>9-26-72</b>		<b>11:00 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE			
<b>Veterans Administration Hospital</b>				<b>Maryland</b>			
<b>3900 Loch Raven Boulevard</b>				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
<b>Baltimore, Maryland 21218</b>				<b>Baltimore</b>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX				6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
<b>Male</b>		<b>Negro</b>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
<b>23</b>		<b>23</b>		<b>5-22-94</b>		<b>78</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<b>Laborer</b>				<b>1102 Druid Avenue</b>		<b>Baltimore, Maryland</b>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<b>Edward Chisley</b>				<b>Mary Grayson</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
<b>Yes</b>				<b>219-32-0464</b>		<b>VA Hospital Records</b>	
<b>World War 1</b>				<b>Baltimore, Maryland 21218</b>		<b>Address</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <i>Pulmonary emboli - multiple 24 hrs.</i>			
II				(C) <i>Congestive heart failure 2 years.</i>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				20A. AUTOPSY? (Yes or No)			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
<b>22</b>				<b>Yes</b>		<b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
<b>22</b>				<b>While At Work</b>		<b>While At Work</b>	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>September 26, 1972</b> to <b>September 26, 1972</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>September 26, 1972</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
<b>Alan G. Stahl, M.D.</b>				<b>9-28-72</b>		<b>MD</b>	
23D. ADDRESS				24A. BURIAL CREMATION, REMOVAL (Specify)			
<b>3900 Loch Raven Boulevard</b>				<b>B</b>			
<b>Baltimore, Maryland 21218</b>				<b>urial</b>			
24B. DATE				24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
<b>10/2/72</b>				<b>Valley Forge National</b>		<b>Gettysburg Penn</b>	
25A. DATE REC'D BY HEALTH DEPT				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
<b>SEP 29 1972</b>				<b>Adolphus Halstead</b>		<b>1206 W Nroth Ave</b>	



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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>HUGH TIMOTHY FLYNN</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY HOSPITAL (DOA)</b> (If not in hospital or institution, give street address or location)		3. DATE PRONOUNCED DEAD Month Day Year <b>September 27, 1972</b> Hour <b>12:30</b> M. <b>A</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>5210</b>	
9. DATE OF BIRTH <b>9-3-1933</b>		10. AGE (In years last birthday) <b>39</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>DIST. OF COLUMBIA</b>		12. CITIZEN OF <b>U. S. A.</b>	
13. FATHER'S NAME <b>HUGH P. FLYNN</b>		14. MOTHER'S MAIDEN NAME <b>ELLA ROCHE</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MORTGAGE BANKER</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>BANKING</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <b>YES NA NA XX</b>		16. SOCIAL SECURITY NO. <b>577-44-5554</b>	
17. INFORMANT <b>MRS. BEVERLY F. FLYNN</b>		18. ADDRESS <b>ITEM 5</b>	
19. CAUSE OF DEATH <b>Multiple Injuries</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>21</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>	
22D. TIME OF INJURY (APPROX.) <b>9-26-72 11:30 P.m.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? <b>Driver in auto-truck collision</b>		21. AUTOPSY? (Yes or No) <b>yes</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> M.D. EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>9-29-72</b>	
24C. NAME of CEMETERY or CREMATORY <b>GATE OF HEAVEN CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>SILVER SPRING, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 29 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Robinson</b>	
25C. FUNERAL DIRECTOR <b>Gallen's Son's Inc.</b>		25D. ADDRESS <b>5130 Wisconsin Ave. N.W. Washington, D.C.</b>	

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

WASHINGTON, D. C.

DEPT. OF COMMERCE

U. S. A.

WASH. D. C.

NO. 11

44-11-11

NO. 11

Washington, D. C.

SECRET

9-10-72

*[Handwritten signature]*  
Harold N. Rosenberg, M.D.

9-10-72

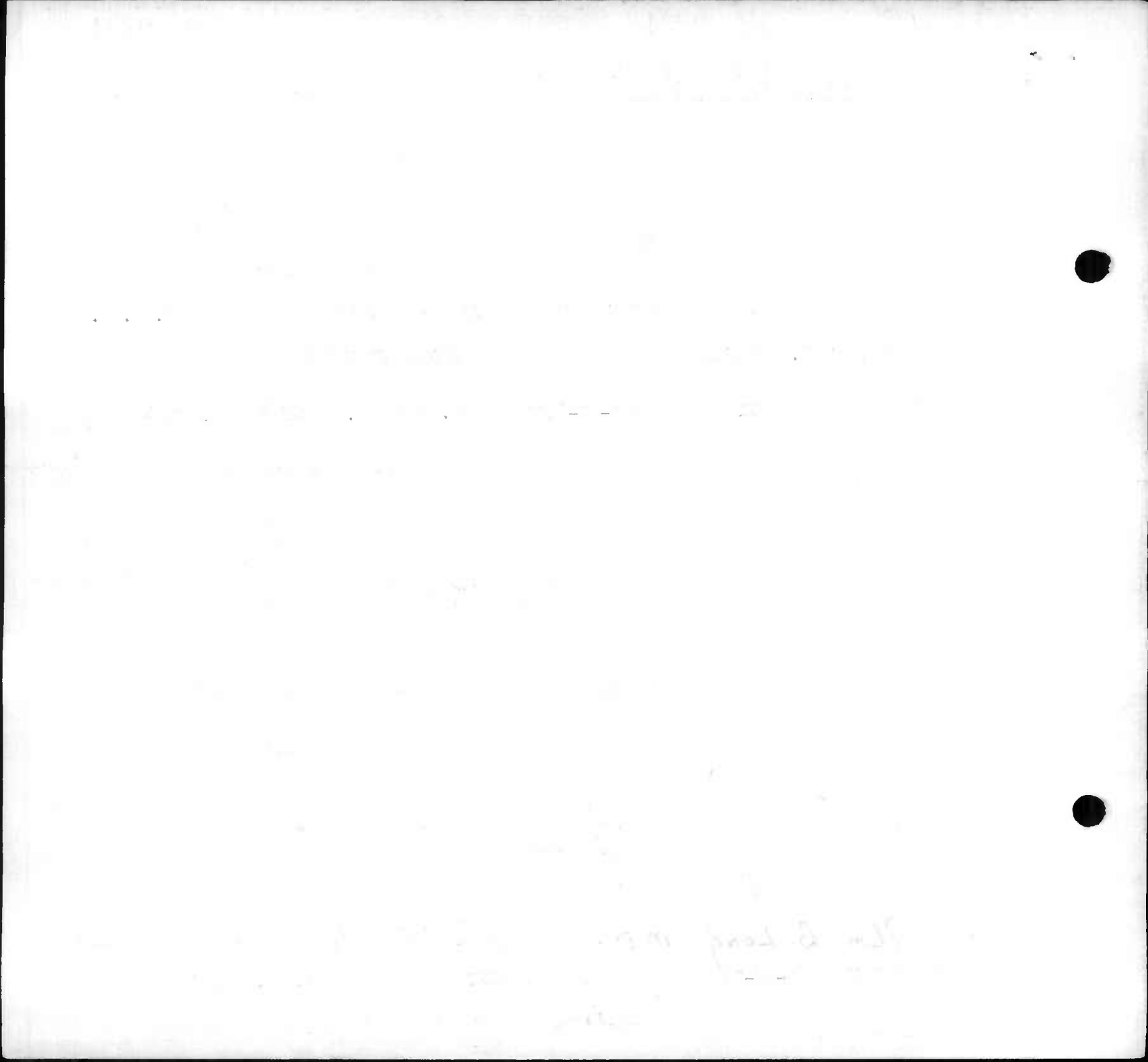
JANUARY

U. S. DEPARTMENT OF JUSTICE

WASHINGTON, D. C.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-160		72 09294		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09294	
CERTIFICATE OF DEATH				STATE OF MARYLAND-DMH			
1. NAME OF DECEASED (Type or Print) <b>ROBERT JOHNSTON WEAVER</b>				2. DATE AND HOUR OF DEATH <b>September 26, 1972 10<sup>13</sup> P. M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>38 University Hospital</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Montgomery</b>			
5. SEX <b>M</b>		6. RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-1-18</b>	
9. AGE in years (lost birthday) <b>54</b>		10. If Under 1 Yr. Months: Days: Hours: Min.		11. BIRTHPLACE (State or foreign country) <b>NEWARK OHIO</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ADVISORY CONSULTANT</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>ENGINEERING</b>			
13. FATHER'S NAME <b>GEORGE H. WEAVER</b>				14. MOTHER'S MAIDEN NAME <b>MABLE JOHNSTON</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <b>YES WW II</b>		16. SOCIAL SECURITY NO. <b>302-09-8930</b>		17. INFORMANT <b>MRS. JOAN T. WEAVER</b>		ADDRESS <b>ITEM 4</b>	
18. CAUSE OF DEATH <b>367-31</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>SEPTICAEMLIC SHOCK</b>				<b>2 WEEKS</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <b>GENERALIZED PERITONITIS</b> <b>3 WEEKS</b>			
				(B) <b>GASTRO JEJUNAL-COLIC FISTULA</b> <b>4 WEEKS</b>			
				(C) <b>SEJUNAL FISTULA</b> <b>2 WEEKS</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>9-6-72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>GASTRO JEJUNAL-COLIC FISTULA</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from <b>September 6, 1972</b> to <b>September 26, 1972</b> that (we) lost saw the deceased alive on <b>September 26, 1972</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>William B. Long M.D.</b>				23B. DATE SIGNED <b>Sept 26, 1972</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <b>Wm. B. Long M.D.</b>				23D. ADDRESS <b>STAFF Univ. Hospital Baltimore</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>CREMATION</b>		24B. DATE <b>9-29-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CREMATORY</b>		24D. LOCATION (City, town, or county) (State) <b>SUITLAND, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 29 1972</b>		25B. NAME OF REGISTRAR <b>Sidney H. Johnston</b>		25C. FUNERAL DIRECTOR <b>BRAWLER'S SONS INC.</b> ADDRESS <b>5130 WISC. AVE., N. W. WASH., D. C. 20016</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
R-300		72 09295		72 09295	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Ida B. Roth		September 24, 1972 8:35 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE			
90 The Wesley Home, Inc.		Maryland			
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		2211 West Rogers Avenue			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 Yr. Months: Days
F	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	October 6, 1874	97	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housekeeper		St. Timothy's School		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
John Frederick Roth		Emma V. Hardesty			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		218 52 1193JL		The Wesley Home, Inc.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
412.41 + 173.3					
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		Ischemic cardiac disease			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Squamous cell carcinoma of the			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
0		No			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12 July 1970 to 24 September 1972, that (I) (we) last saw the deceased alive on 24 September 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
John W. Barnaby		26 Sept 72			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. John W. Barnaby		1652 East Belvedere Avenue			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	27 Sept 72	Parkwood Cemetery		Parkville, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF FUNERAL DIRECTOR		25C. FUNERAL DIRECTOR'S ADDRESS	
SEP 29 1972		Audrey H. Heston		Burgeer Funeral Home, Balto., Md.	
		Walter V. Heston			

N. H. 70 call back.

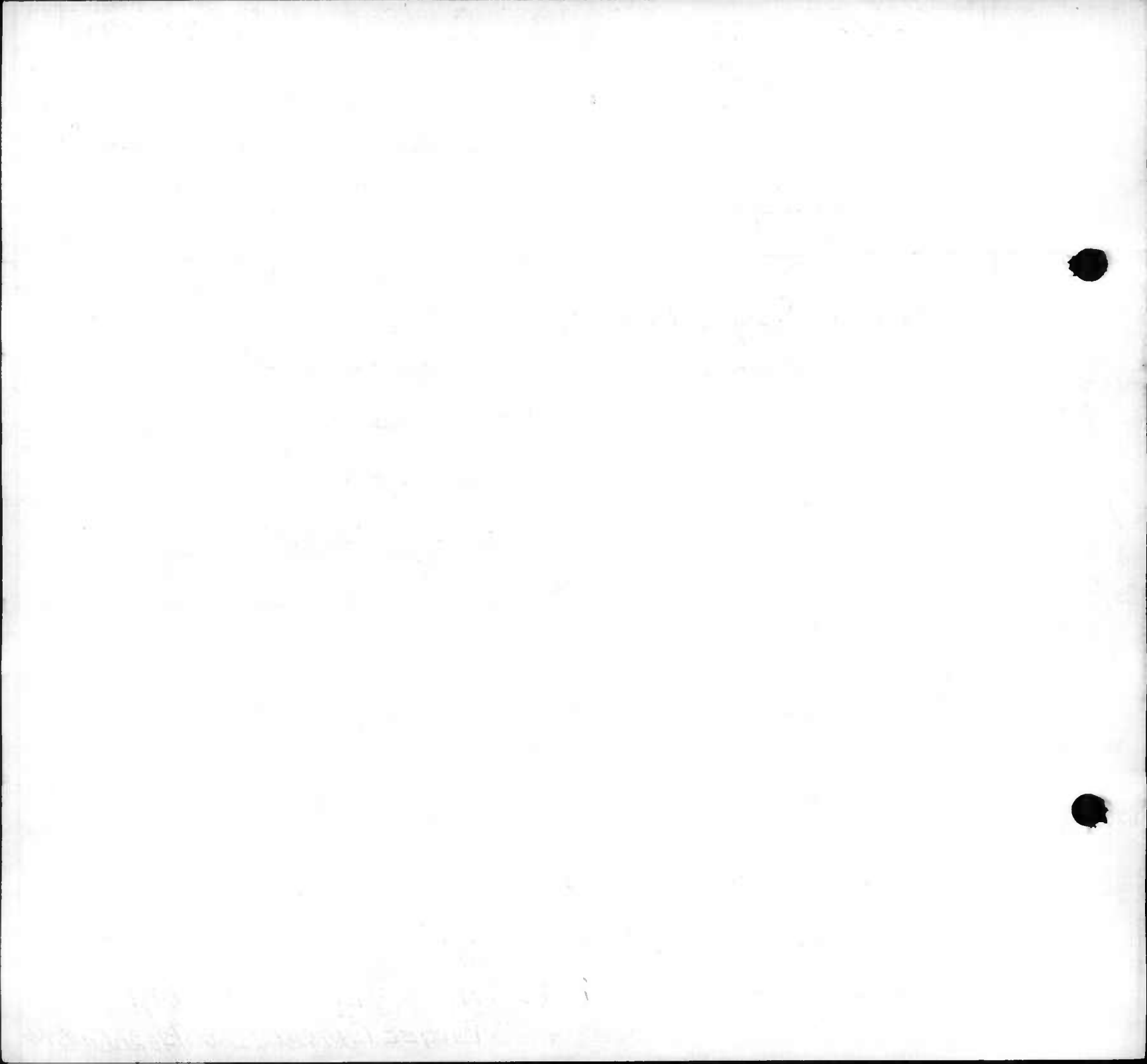
Adm. 1954



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-610		72 09296		BALTIMORE CITY HEALTH DEPARTMENT		72 09296	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print)				STATE OF MARYLAND-DHME			
Sharff, Frances				2. DATE AND HOUR OF DEATH Sept. 23, 1972 2:35 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
North Charles General Hosp. 2724 North Charles Street.				3939 Roland Ave Apt. 213			
5. SEX				6. RACE			
Fe				W			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH			
5-9-04				9. AGE (In years last birthday) 68			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY			
Retired Sec'y Veterans Adm				md.			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
md.				U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Ernest Sharff				Katherine Snowden			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
No				215-22-2866			
17. INFORMANT				ADDRESS			
Admission Sheet				Admission Sheet			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CVA + Post. Myocardial Infarction			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Severe arterial insufficiency Rt leg			
(C) Spontaneous CVD							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from 8-4 1972 to 9-23 1972 that (H) (we) last saw the deceased alive on 9-23 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Eduardo C. Yanco, M.D.				9-23-72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Eduardo C. Yanco, M.D.				North Charles Gen. Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		9/26/72		Dreid Ridge Cem.		Baltimore Co Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
SEP 29 1972		Sidney H. Hinton		BURGEE FUNERAL HOME		3134 E. 15th St	



1

W-300 72 09297

STATE OF MARYLAND - DISTRICT  
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 09297

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>RALPH E. WOODY</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>University Hospital 3-1-73</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour M. <b>9 25 1972 12:20p</b>	
6. SEX <b>male</b>		7. RACE <b>white</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Elkton</b>	
9. DATE OF BIRTH <b>April 8, 1932</b>		10. AGE (In years last birthday) <b>40 yrs.</b>	
11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>J.C. Woody</b>		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Cecil</b> <b>5700</b>	
15. STREET AND NUMBER <b>Rt. 3 Box 345</b>		16. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
17. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Assembly</b>		18. KIND OF BUSINESS OR INDUSTRY <b>Chrysler Corp.</b>	
19. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		20. SOCIAL SECURITY NO. <b>258-44-4091</b>	
21. INFORMANT <b>Hospital Records</b>		22. ADDRESS	
19. CAUSE OF DEATH <b>Gunshot wound of head</b> (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION <b>9-24-72</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>home</b>	
22C. WHERE DID INJURY OCCUR? <b>Rt. 3 Box 345</b>		22D. TIME (Month) (Day) (Year) (Hour) (Approx.) <b>9-24-72 5:45 a.m.</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Allegedly shot by as yet unidentified member of his family.</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>9-25-72</b>			
ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	
24B. DATE <b>9/28/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Union Methodst Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Union, Cecil Co. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 29 1972</b>	
25B. NAME OF REGISTRAR <b>Shirley H. Hinton</b>		25C. FUNERAL DIRECTOR <b>Harold E. Hicks</b>	
25D. ADDRESS <b>Hicks Home for Funerals, Elkton, Md.</b>			

VS 151-REV. 1/1/68

3-1-1973 - Letter from the Office of the Chief Medical Examiner, Russell S. Fisher, M.D.,  
Chief Medical Examiner. hs

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09298
CERTIFICATE OF DEATH				REG. NO. 72 09298
STATE OF MARYLAND-DEME				
1. NAME OF DECEASED (Type or Print) <b>ANNA RAUTIS</b>		2. DATE AND HOUR OF DEATH <b>SEPTEMBER 28, 1972 4:15 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE CITY</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>MARYLAND GENERAL HOSPITAL</b>		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <b>F</b> 6. RACE <b>W</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <b>1919 PARK AVE.</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEMAKER</b>		11. BIRTHPLACE (State or foreign country) <b>LITHUANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>LITHUANIA</b>
13. FATHER'S NAME <b>BALTRUS KABILUS</b>		14. MOTHER'S MAIDEN NAME <b>ANNA MICKIEWICZ</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>AS-09-7891</b>		17. INFORMANT <b>DELORIS M. PLASIEWICZ</b> ADDRESS <b>SOME AS 4 E</b>
18. <b>412.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>INTRACRANIAL HEMORRHAGE</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>9 HRS</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>HYPERTENSIVE CARDIOVASCULAR DIS.</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		<b>MYOCARDIAL INFARCTION-UNDIETERMINED REGENCY.</b> <b>UNKNOWN</b>		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (H) (this hospital) attended the deceased from <b>SEPT. 27, 1972</b> to <b>SEPT. 28, 1972</b> that (H) (we) last saw the deceased alive on <b>SEPT. 28, 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Harry A. Spatt</b>		23B. DATE SIGNED <b>9/28/72</b>		23C. PHYSICIAN'S NAME (Type) <b>HARRY A. SPATT MD</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10-2-1972</b>		24C. NAME OF CEMETERY <b>Holy Trinity Cemetery</b>
24D. LOCATION <b>BEAR CREEK TOWNSHIP PA.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 29 1972</b>		
25B. NAME OF REGISTRAR <b>Sidney Johnston</b>		25C. FUNERAL DIRECTOR <b>Wm Cook-Briggs Towson, Inc. Towson, Md</b>		

4. Make Own home

Julius Kaps

1911-1912

Ann M. Kaps

Address in Germany

2000-1911

These A. Kaps

These A. Kaps

These A. Kaps

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 09299</b>
72 09299				STATE OF MARYLAND
BIRTH NO. <b>N-425</b>		2. DATE AND HOUR OF DEATH <b>SEPTEMBER 26, 1972 11:30A</b>		
1. NAME OF DECEASED (Type or Print) <b>NELSON, JOSEPH C</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2531</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>ST. AGNES HOSPITAL</b>		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <b>4707 FREDERICK AVE 21229</b>				
5. SEX <b>MALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/28/93</b>	9. AGE (In years last birthday) <b>76 77</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SUPERINTENDENT</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>CO</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
13. FATHER'S NAME <b>GEORGE NELSON</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NONE</b>		16. SOCIAL SECURITY NO. <b>215-07-5291</b>		
17. INFORMANT <b>ST. AGNES HOSPITAL RECORDS</b>		ADDRESS		
18. <b>427.01-230.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ACUTE Pulmonary Edema</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Chronic Congestive Heart Failure - D.M.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>SEPTEMBER 18 1972</b> to <b>SEPTEMBER 26 1972</b> , that (I) (we) last saw the deceased alive on <b>SEPTEMBER 26 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>S. N. MOUSSAVIAN, M.D.</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>09 26 72</b>
23C. PHYSICIAN'S NAME (Type) <b>SEYED N. MOUSSAVIAN, M. D.</b>		23D. ADDRESS <b>BALTIMORE, MD 21229</b> <b>ST. AGNES HOSPITAL; CATON &amp; WILKENS AVE</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/29/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 29 1972</b>		25B. NAME OF REGISTRAR <b>Edw. S. MacNabb Sons, Inc.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>301 Frederick Avenue Catonsville, Md</b>





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09300	
72 09300 CERTIFICATE OF DEATH				REG. NO. 72 09300	
STATE OF MARYLAND - DISTRICT				DATE	
1. NAME OF DECEASED (Type or Print) <b>SHONAKER, BERTHA FRIEDA</b>		2. DATE AND HOUR OF DEATH <b>9/22/72</b> <b>725 PM</b> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>42 SINAI HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>2802</b>			
5. SEX <b>F</b>		6. RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		8. DATE OF BIRTH <b>NOV. 27, 1896</b>	
13. FATHER'S NAME <b>MICHAEL K. HARWITH</b>		14. MOTHER'S MAIDEN NAME <b>MARIE STETTNER</b>		9. AGE (in years last birthday) <b>75</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b> <b>NONE</b>		16. SOCIAL SECURITY NO. <b>D 220-30-3137</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <b>Ovarian Carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>A.S.H.D., U.T.I. &amp; sepsis,</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Cardiorespiratory arrest.</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>9/23/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9 PM 9/22</b> 19 <b>72</b> to <b>PM 9/22/72</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>9/22/72</b> 19 <b>72</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>[Signature]</b>		23B. DATE SIGNED <b>9/24/72</b>		23C. PHYSICIAN'S NAME (Type) <b>A. Antonopoulos MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>SEP 29 1972</b>		24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn Cemetery</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 29 1972</b>		25B. NAME OF REGISTRAR <b>Ludwig W. [Signature]</b>		25C. FUNERAL DIRECTOR <b>Frank H. Newell</b>	
25D. ADDRESS <b>Sinai Hospital</b>		25E. ADDRESS <b>2802 [Address]</b>			

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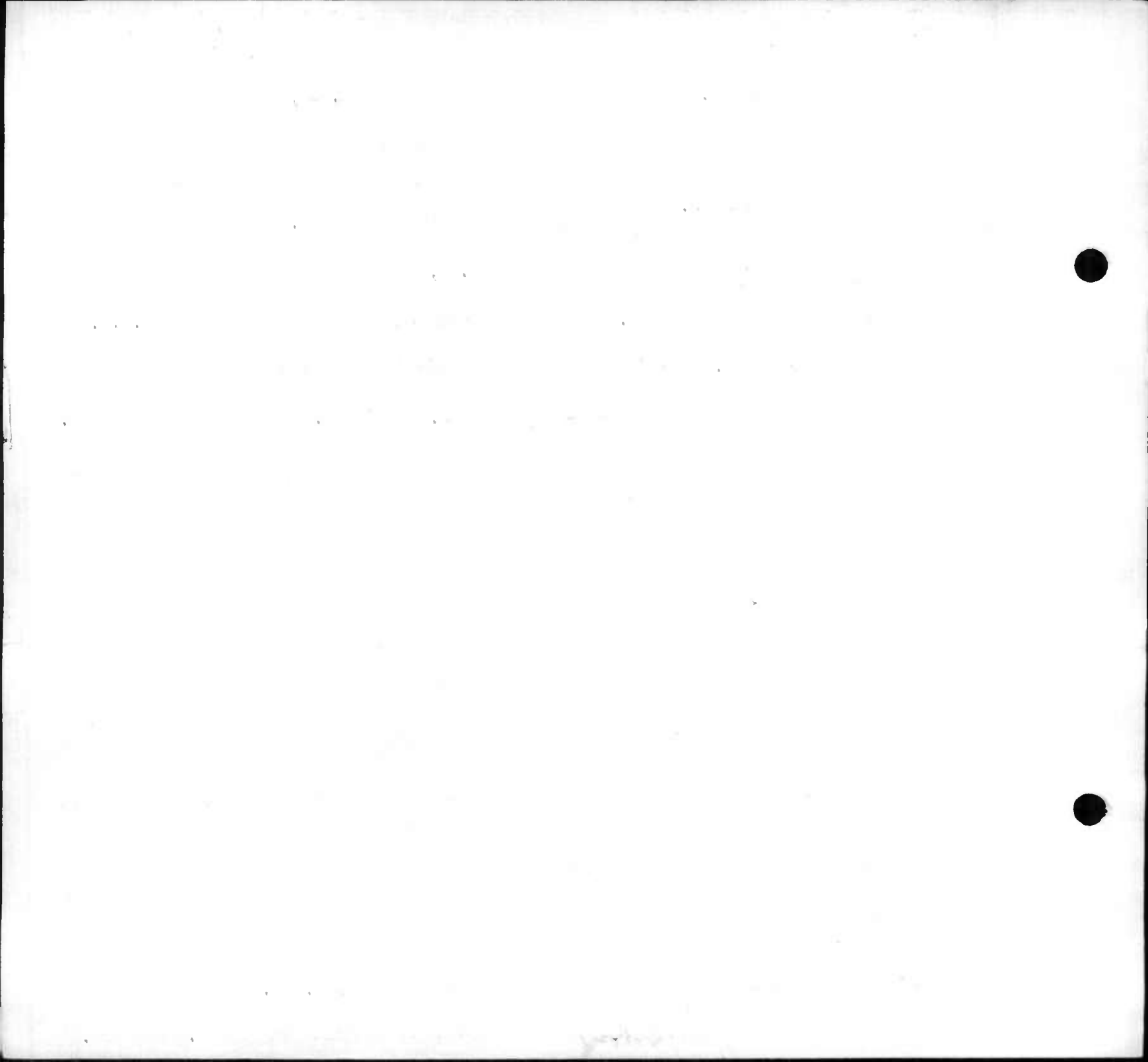
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <b>72 09301</b>
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <i>Norbert A. Phillips</i>		<b>2. DATE AND HOUR OF DEATH</b> <i>Sept. 28, 1972</i> <span style="float: right;">1 2 A.M.</span>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>00 1253 William St.</i>		<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2403</i> <b>C. CITY OR TOWN</b> <i>Baltimore</i> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <i>1253 William St.</i>		
<b>5. SEX</b> <i>M</i>	<b>6. RACE</b> <i>W</i>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <i>Nov. 19, 1914</i>	<b>9. AGE</b> (In years last birthday) <i>57</i> If Under 1 Yr. Months Days If Under 24 Hrs. Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Driver</i>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <i>Cab Co.</i>		
<b>11. BIRTHPLACE</b> (State or foreign country) <i>Maryland</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>U.S.A.</i>		
<b>13. FATHER'S NAME</b> <i>William W. Phillips</i>		<b>14. MOTHER'S MAIDEN NAME</b> <i>Lillian Randolph</i>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		<b>16. SOCIAL SECURITY NO.</b> <i>220-14-6273</i>		
<b>17. INFORMANT</b> <i>Mrs. William A. Hyser</i>		<b>ADDRESS</b> <i>1253 William St.</i>		
<b>18. CAUSE OF DEATH</b>				
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>                              (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p><b>ANTECEDENT CAUSES</b>                              DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 50%;"> <p><b>(A) IMMEDIATE CAUSE</b> <i>Cirrhosis of Liver</i>                              DUE TO, OR AS A CONSEQUENCE OF:</p> <p><b>(B)</b> DUE TO, OR AS A CONSEQUENCE OF:</p> <p><b>(C)</b> DUE TO, OR AS A CONSEQUENCE OF:</p> </div> </div> <p style="text-align: right;">APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 month.</i></p>				
<b>II</b>				
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>				
<b>19A. DATE OF OPERATION</b> <i>0</i>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		
<b>20A. AUTOPSY?</b> (Yes or No) <i>NO</i>		<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>		
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		
<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)		<b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)		
<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>		
<b>22. I certify that (1) (this hospital) attended the deceased from <i>Sept 8</i> 19 <i>72</i> to <i>Sept 23</i> 19 <i>72</i> that (1) (we) last saw the deceased alive on <i>Sept 23</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.</b>				
<b>23A. SIGNATURE</b> <i>Joseph A. Mead Jr. M.D.</i>		<b>23B. DATE SIGNED</b> <i>Sept 28, 1972</i>		<b>23C. PHYSICIAN'S NAME (Type)</b> <i>Joseph A. Mead Jr. M.D.</i>
<b>23D. ADDRESS</b> <i>301 St Paul Place, Baltimore, Maryland</i>		<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <i>Burial</i>		
<b>24B. DATE</b> <i>10-2-72</i>		<b>24C. NAME OF CEMETERY OR CREMATORY</b> <i>New Cathedral Cemetery</i>		
<b>24D. LOCATION</b> (City, town, or county) (State) <i>Balto. Md.</i>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <i>SEP 29 1972</i>		
<b>25B. NAME OF REGISTRAR</b> <i>Sidney Jackson</i>		<b>25C. FUNERAL DIRECTOR</b> <i>McGully Funeral Home 130 E. Fort Ave. 21230</i>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09302	
BIRTH NO. <span style="float: right;">72 09302</span>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Baldwin, Nelson</i>				2. DATE AND HOUR OF DEATH <i>9-26-72</i> <span style="float: right;">4:30 P.M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Ind.</i> B. COUNTY <i>1306</i>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>90 Oakland Nursing Home</i>				C. CITY OR TOWN <i>Balto.</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>Oakland Home 1501 N. Oakland</i>					
5. SEX <i>Male</i>		6. RACE <i>Cauc.</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>3/18/94</i>		9. AGE (In years last birthday) <i>78</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Baldwin</i>	
11. BIRTHPLACE (State or foreign country) <i>Ind.</i>		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>?</i>	
14. MOTHER'S MAIDEN NAME <i>?</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>yes WWI</i>		16. SOCIAL SECURITY NO. <i>217-01-7504</i>	
17. INFORMANT <i>Leonard Baldwin</i>		ADDRESS <i>3505 Falls Rd.</i>		18. <i>185X I</i> CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <i>Metastatic Ca</i> DUE TO, OR AS A CONSEQUENCE OF:  (B) <i>Ca of Prostate</i> DUE TO, OR AS A CONSEQUENCE OF:  (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1-7-1972</i> to <i>9-26-1972</i> that (I) (we) last saw the deceased alive on <i>9-26-1972</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Perceval P. Smith, M.D.</i>				23B. DATE SIGNED <i>9-26-72</i>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS <i>DEGREE</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9/29/72</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Fullerton</i>	
24D. LOCATION (City, town, or county) (State) <i>Balto. Ind.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>SEP 29 1972</i>		25B. NAME OF REGISTRAR <i>Sidney W. Horton</i>	
25C. FUNERAL DIRECTOR <i>Chas. E. Chas. 3617 Chestnut Ave.</i>		ADDRESS			

117/72 - Adm.  
3414 Chestnut Ave



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>EUGENE H. OWENS, Sr.</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2518 E. Preston Street</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>September 22, 1972</b> Hour <b>9:05 A.</b> M.	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>833</b>	
9. DATE OF BIRTH <b>Sept 16, 93</b>		10. AGE (In years last birthday) <b>79</b> If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Lawrenceville, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Rawlings</b>		14. MOTHER'S MAIDEN NAME <b>Fannie D. Owens</b>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		18. SOCIAL SECURITY NO.	
19. INFORMANT <b>Dr. Eugene H. Owens 6715 Wesbrook Rd.. 21215</b>		ADDRESS	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>no</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>9/22/72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-26-72</b>	
24C. NAME of CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 29 1972</b>		25B. NAME OF REGISTRAR <b>Aldrey H. [Signature]</b>	
25C. FUNERAL DIRECTOR <b>1735 Harford Ave. 21213</b>		25D. NAME OF FUNERAL HOME <b>Marshall W. Jones, Jr.</b>	

75-0000

UNITED STATES DEPARTMENT OF JUSTICE

WASHINGTON, D.C.

February 10, 1953

Page 10 of 12

Mr. J. Edgar Hoover

U.S.A.

Washington, D.C.

Dear Mr. Hoover:

Enclosed for you are

two copies of a letterhead memorandum

no.

dated and captioned as above.

Very

Very truly yours,  
[Signature]

Director, FBI

Special Agent in Charge

2-10-53

Enclosure

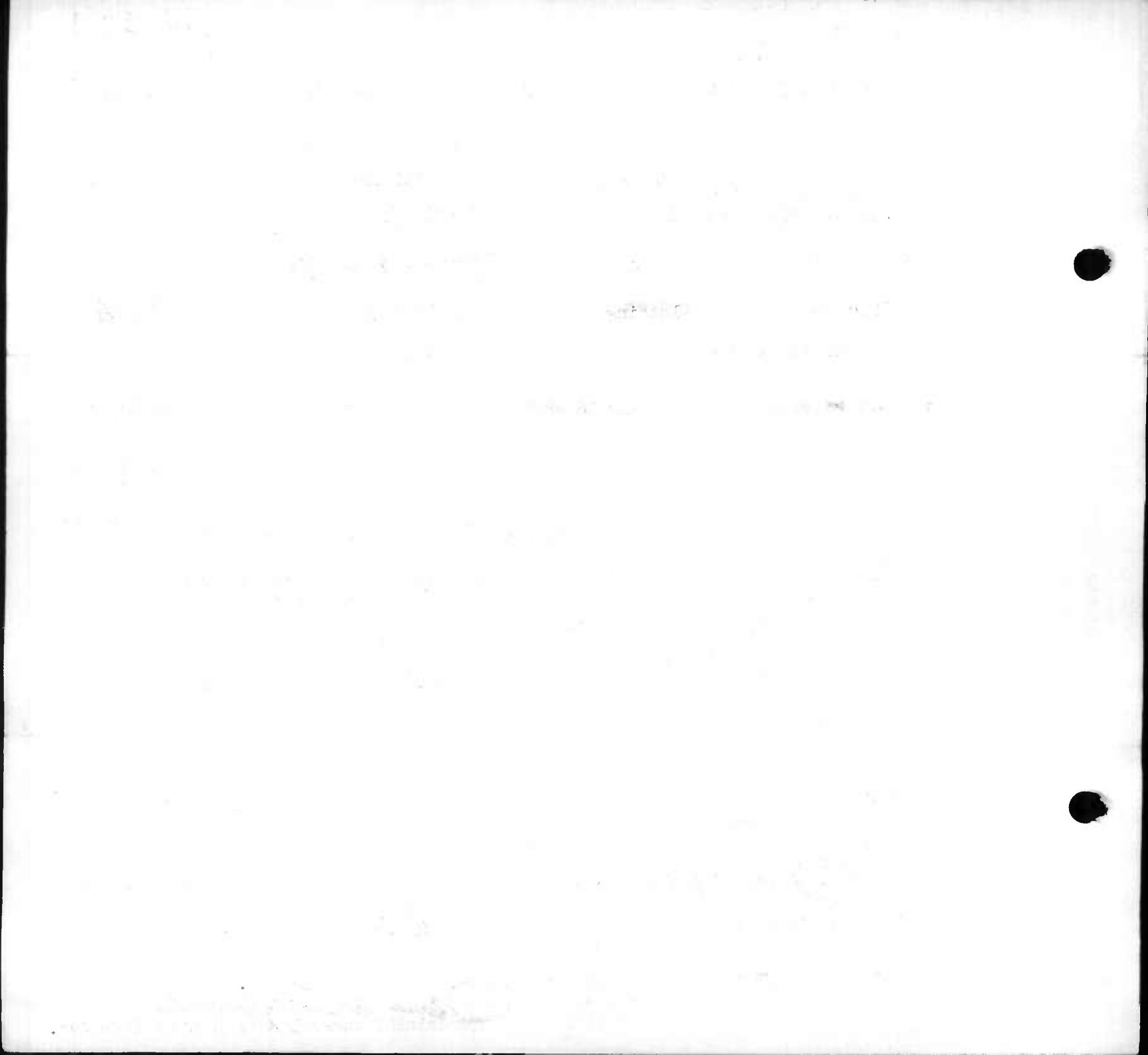
Very truly yours,  
[Signature]

Special Agent in Charge

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

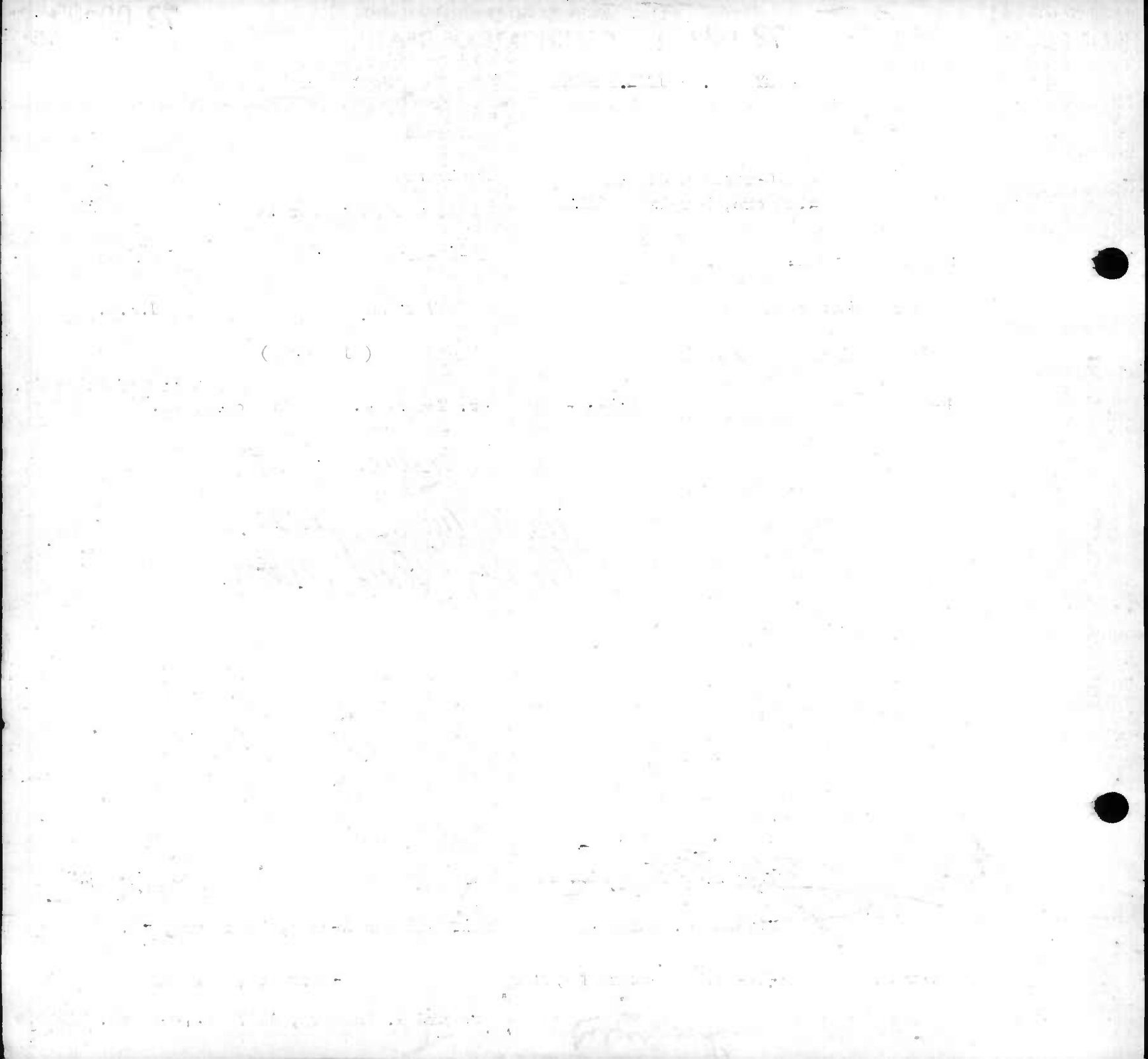
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>54-22-09304</b>	
M-212 72 09304				STATE OF MARYLAND DEPT	
1. NAME OF DECEASED (Type or Print) <b>MACKEVICH JOHN MATHEW</b>		2. DATE AND HOUR OF DEATH <b>Sept 26, 1972 11:45 AM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Baltimore City Hospital Baltimore MD 21224</b>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>803 S. Woodlawn Rd. 21221</b>			
5. SEX <b>Male</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 24/1882</b>		9. AGE (In years last birthday) <b>91 yrs.</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tailor</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Clothing</b>		11. BIRTHPLACE (State or foreign country) <b>LITHUANIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13. FATHER'S NAME <b>MATHEW</b>			
14. MOTHER'S MAIDEN NAME <b>Eve</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>217 26 8243</b>		17. INFORMANT ADDRESS <b>Elyzita Madzregor (Niece) 803 S. Woodlawn Rd #21</b>			
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ACUTE MYOCARDIAL INFARCTION Sudden</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Many yrs.</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>(Previous)</b>			
		(B) <b>Ascend + Chronic Brain Syndrome</b> DUE TO, OR AS A CONSEQUENCE OF:			
		(C) <b>Hemiparesis, planning Hemiparesis</b> (? SOURCE)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Arteriosclerotic Cardiovascular Disease</b>					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>July 7th 1971</b> to <b>Sept 26 1972</b> that (I) (we) last saw the deceased alive on <b>Sept 26 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>G. M. NASIM M.D.</b>		23B. DATE SIGNED <b>Sept 26, 72</b>		23C. PHYSICIAN'S NAME (Type) <b>G. M. NASIM M.D.</b>	
23D. ADDRESS <b>Baltimore City Hospital</b>		23E. FUNERAL DIRECTOR'S NAME (Type) <b>Pruddzinski Funeral Home</b>			
23F. ADDRESS <b>1407 Eastern Ave.</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>9/29/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 29 1972</b>		25B. NAME OF REGISTRAR <b>Dudley H. H. H.</b>		25C. NAME OF REGISTRAR <b>Pruddzinski Funeral Home</b>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 09305		72 09305	
BIRTH NO. <b>B-342</b>		72 09305		REG. NO. <b>72 09305</b>	
1. NAME OF DECEASED (Type or Print)		MARY E. BEUTELSPACHER		2. DATE AND HOUR OF DEATH September 26, 1972	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		M.	
FULL NAME OF HOSPITAL OR INSTITUTION  00 2411 Christian Street Baltimore, Maryland 21223		A. STATE Maryland		B. COUNTY 2005	
C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 2411 Christian Street 21223	
5. SEX Female		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 12-28-1907		9. AGE (In years last birthday) 64		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Nurses Aid		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Fisher		14. MOTHER'S MAIDEN NAME Zula (Unknown)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-18-7219		17. INFORMANT Mr. Thomas W. Beutelspacher, Sr. 21223	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Due to, OR AS A CONSEQUENCE OF: <i>Cordeac Arrest</i> (B) <i>Acute Angina pectoris</i> Due to, OR AS A CONSEQUENCE OF: (C) <i>Crown Heart disease</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE <i>Miguel A. Heredia</i>		23B. DATE SIGNED 9/27/72		23C. PHYSICIAN'S NAME (Type) Miguel A. Heredia	
23D. ADDRESS 3350 Wilkens Avenue, Baltimore, Md.		23E. NAME OF REGISTRAR Howard H. Hubbard		23F. FUNERAL DIRECTOR ADDRESS 4107 Wilkens Ave. 21229	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-29-1972		24C. NAME OF CEMETERY or CREMATORY Western Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. SEP 29 1972		25B. NAME OF REGISTRAR Sidney H. Hubbard	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>72 09306</u>	
BIRTH NO. <u>B-500</u> <u>72 09306</u>				STATE OF MARYLAND-DIGEST			
1. NAME OF DECEASED (Type or Print) <u>BOWEN, CURTIS A</u>				2. DATE AND HOUR OF DEATH <u>SEPTEMBER 26, 1972</u> <u>9:05A</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>40 ST. AGNES HOSPITAL</u>				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>4903 WILKENS AVE 21228</u>			
5. SEX <u>MALE</u>	6. RACE <u>CAUCASIAN</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/06/99</u>	9. AGE (In years last birthday) <u>72</u>	10. Under 1 Yr. Months: Days	11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STEAMFITTER</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>GAS &amp; ELECTRIC CO</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Walter Bowen</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE FRANKLIN BOWEN (Moxley)</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WORLD WAR 1 &amp; 2</u>				16. SOCIAL SECURITY NO. <u>218-01-6666</u>		17. INFORMANT <u>ST. AGNES HOSPITAL RECORDS</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Metastatic carcinoma of brain &amp; carcinoma of Prostate</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
21A. DATE OF OPERATION <u>SEPTEMBER 20, 1972</u>		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>NO</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>SEPTEMBER 20, 1972</u> to <u>SEPTEMBER 26, 1972</u> , that (I) (we) lost saw the deceased alive on <u>SEPTEMBER 26, 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>09/26/72</u>			
23C. PHYSICIAN'S NAME (Type) <u>DR. FEREDOUN, M.D.</u>				23D. ADDRESS <u>BALTIMORE, MD 21229</u> <u>ST. AGNES HOSPITAL; CATON &amp; WILKENS AVE</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-30-1972</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Woodlawn, Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 29 1972</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>Hubbard Funeral Home, Inc.</u>		25D. ADDRESS <u>4107 Wilkens Ave.</u>	



MARYLAND BALTIMORE

BALTIMORE

4803 WILKENS AVE 21228

11/1/50

VIRGINIA

WHITE FRANKLIN TOWER (owner)

WORLD WAR II 2 214-1-6142 ST. AGNES HOSPITAL RECORDS

NO

SEPTEMBER 28 1950

SEPTEMBER 28 1950

BALTIMORE, MD 21228

ST. AGNES HOSPITAL 4803 WILKENS AVE

DR. FERGUSON, M.D.

2-20-1950

WORLD WAR II 2 214-1-6142 ST. AGNES HOSPITAL RECORDS

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09307		72 09307	
X-520 72 09307				CERTIFICATE OF DEATH		REG. NO. STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
YOUNG, MARIE HELEN				SEPTEMBER 26, 1972 2:00AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE		B. COUNTY	
00 ST. AGNES HOSPITAL				MARYLAND		BALTIMORE	
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				ARBUTUS		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER			
				1250 LOCUST AVE. 5300			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
FEMALE	CAUCASIAN	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	03 06 99	73	Housewife	MARYLAND	U.S.A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
GEORGE W. KUHLE				ANNA (RUEL)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
				215012944		RECORDS OF ST. AGNES HOSPITAL	
						CATON & WILKENS AVES. BALTO., MD. 21229	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
I				2 days			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				Cerebral Thrombosis			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Diffuse Myocarditis			
				(C) Arteriosclerosis			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (X) (this hospital) attended the deceased from SEPTEMBER 10 19 72 to SEPTEMBER 26 19 72, that (X) (we) last saw the deceased alive on SEPTEMBER 26 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (didn't) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Damian P. Alagia							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
DAMIAN P. ALAGIA				ST. AGNES HOSPITAL			
				CATON & WILKENS AVES. BALTO., MD. 21229			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		9-29-1972		Baltimore National		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
SEP 29 1972		Sidney Johnston		Hubbard Funeral Home		4107 Wilkens Ave.	

1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 26

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

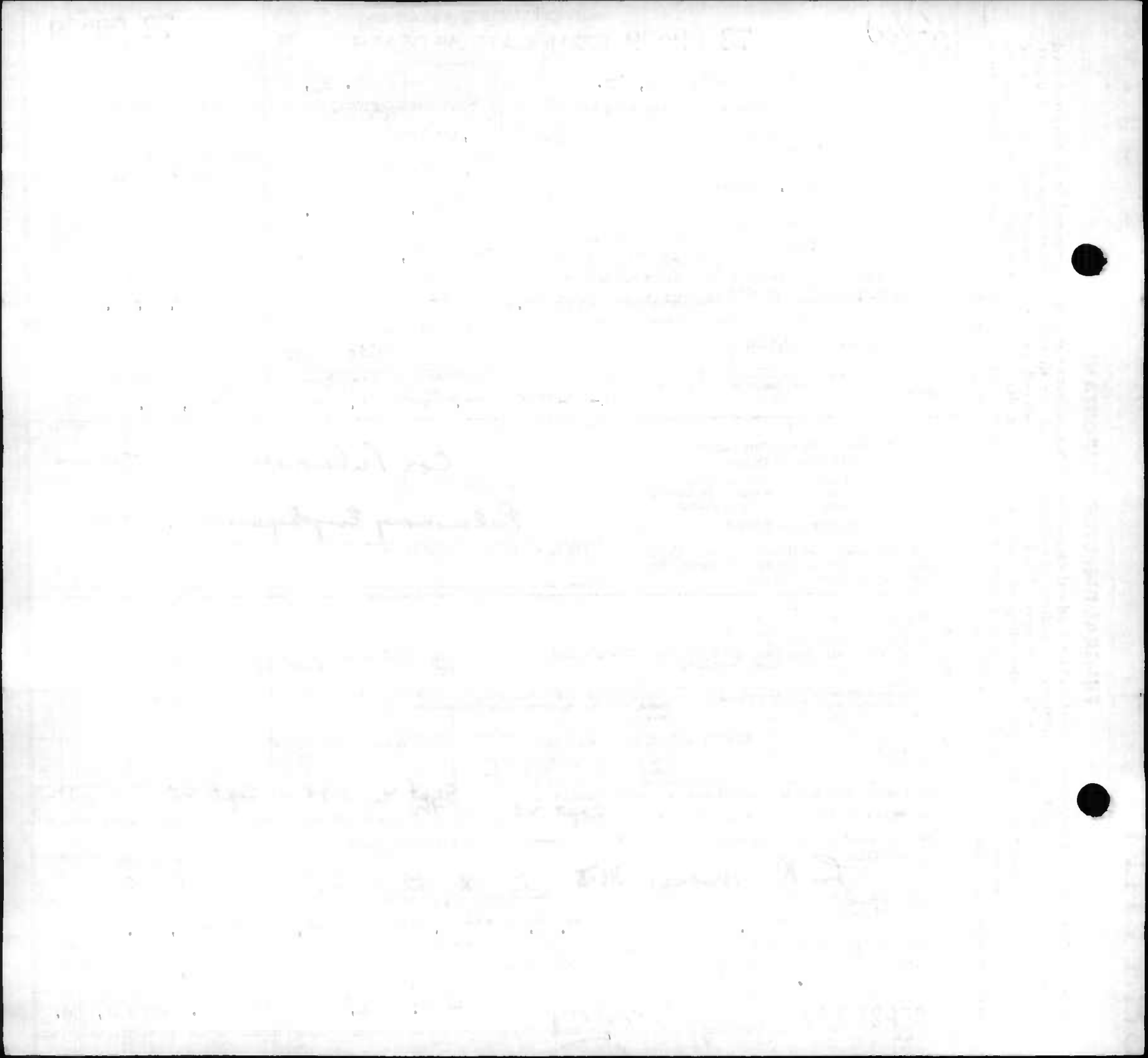
BALTIMORE CITY HEALTH DEPARTMENT		72 09308		72 09308	
Y-000		72 09308		72 09308	
BIRTH NO.		72 09308		72 09308	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		REG. NO.	
YOE, OLGA EDNA		SEPTEMBER 25, 1972		5:05 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		MARYLAND		2864 21229	
40 ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER	
4443 OLD FREDERICK ROAD		S. SEX		6. RACE	
FEMALE		CAUCASIAN		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
01/28/20		52		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
HOUSEWIFE		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
MARYLAND		U.S.A.		13. FATHER'S NAME	
KONSTANT LEBEDA		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
NO		16. SOCIAL SECURITY NO.		17. INFORMANT	
217-09-2694		BALTO MD 21229		ADDRESS	
ST AGNES' RECORDS CATON & WILKENS AVE		18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
199.1 I		Suffocation 2° Aspiration of Vomitus		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(B) Aspiration of Vomitus		DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES		(C) Terminal Cancer		DUE TO, OR AS A CONSEQUENCE OF:	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
NO		NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that XIX (this hospital) attended the deceased from AUGUST 7 19 72 to SEPTEMBER 25 19 72, that (X) (we) last saw the deceased alive on SEPTEMBER 25 19 72 and that in XIX (our) opinion death occurred on the date and hour and from the causes stated above. XIX (We) (did) (did not) view the body after death.		23A. SIGNATURE		23B. DATE SIGNED	
Thomas Jones, M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		09/25/72	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify)	
THOMAS JONES, M.D.		BALTO MD 21229 ST AGNES HOSPITAL CATON & WILKENS AVE		24B. DATE	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT.	
Loudon Park Cemetery		Wilkins Ave. Baltimore, Md.		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR		25D. ADDRESS		25E. DATE REC'D BY HEALTH DEPT.	
Hubbard Funeral Home, 4107 Wilkins Ave.		SEP 29 1972		25F. NAME OF REGISTRAR	
VS 150-REV. 1/1/68		SEP 29 1972		25G. NAME OF REGISTRAR	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09309		72 09309	
<b>K-460</b> BIRTH NO.		<b>72 09309</b> <b>CERTIFICATE OF DEATH</b>				REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>Roy Jay Kohler, Sr.</b>				2. DATE AND HOUR OF DEATH <b>Sept. 25, 1972</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>624 S. Ponca Street</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2607</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>624 S. Ponca St.</b>			
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 17, 1896</b>	
9. AGE (In years last birthday) <b>76</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steel Worker</b>		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George Kohler</b>				14. MOTHER'S MAIDEN NAME <b>Julia Ohler</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <b>Yes WWI</b>		16. SOCIAL SECURITY NO. <b>213-07-2240</b>		17. INFORMANT (Daughter) <b>15 Lombardy Drive</b> <b>Mrs. Martha L. Lane Dundalk, Md. 21222</b>			
18. <b>492X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Cor Pulmonale</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Pulmonary Emphysema</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cor Pulmonale</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Pulmonary Emphysema</b> (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Terminal</b> <b>Years</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Sept 4, 1972</b> to <b>Sept 25, 1972</b> that (I) (we) last saw the deceased alive on <b>Sept 20, 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>L. R. Maser M.D.</b>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>9/26/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Louis R. Maser</b>				23D. ADDRESS <b>M. D. 117 W. 29th Street, Baltimore, Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/28/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 29 1972</b>				25B. NAME OF REGISTRAR <b>Sidney Johnston</b>			
25C. FUNERAL DIRECTOR <b>John J. Duda</b>				ADDRESS <b>7922 Wise Ave. Dundalk, Md.</b>			





# FUNERAL DIRECTOR: IMPORTANT

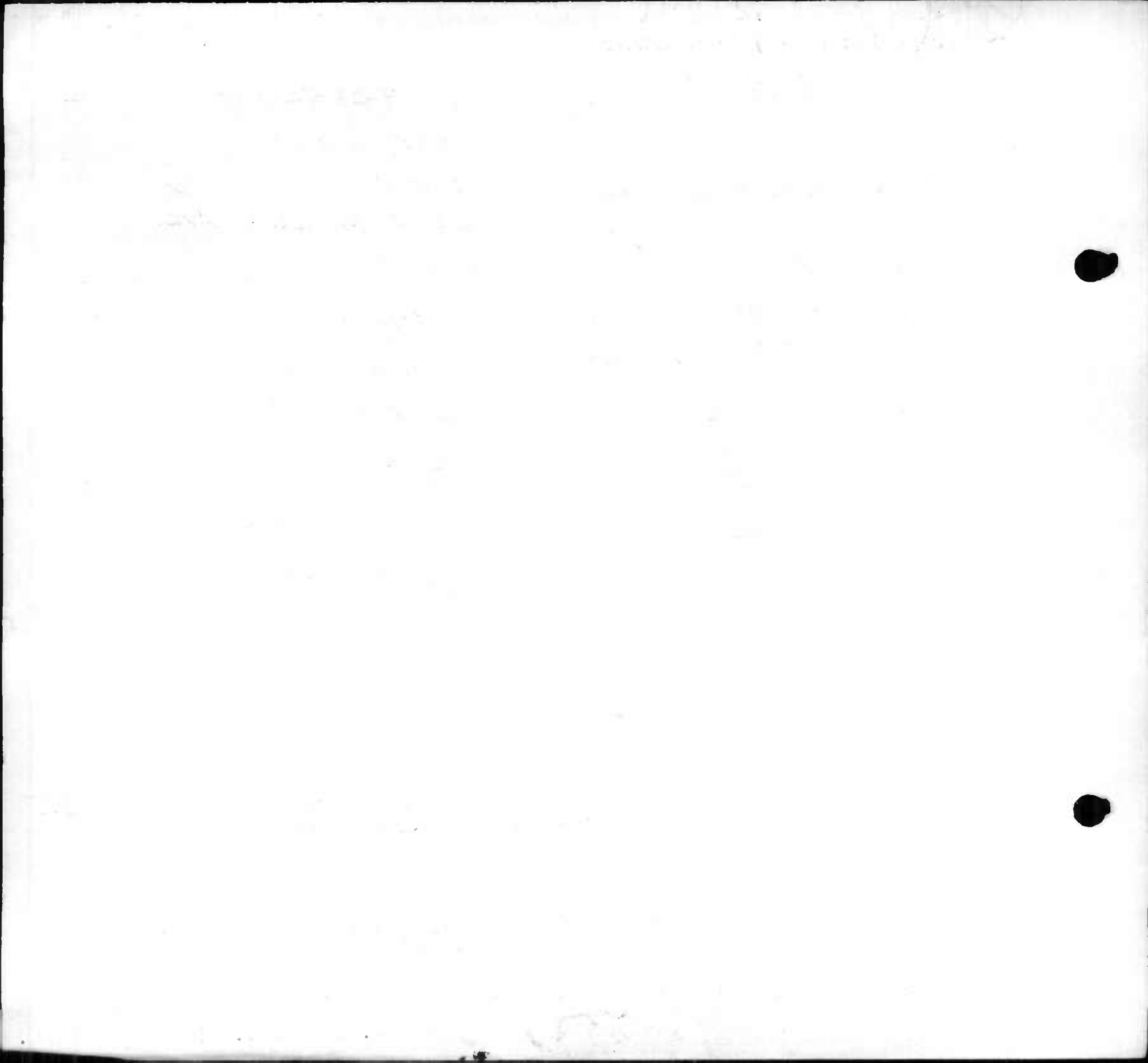
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print) <b>MENGLE, CHARLES H.</b>		2. DATE AND HOUR OF DEATH <b>SEPT. 28, 1972 9.40 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSPITAL</b> <b>44</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2743</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>4819 ARABIA AVE.</b>	
5. SEX <b>M</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>07-07-08</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>National Brewery</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>64</b>
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph MENGLE</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH Niendecker</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WWII</b>		16. SOCIAL SECURITY NO. <b>215-03-7724</b>	17. INFORMANT <b>THELMA M. MENGLE</b>
18. <b>162.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>RESPIRATORY INSUFFICIENCY</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slotting the UNDERLYING CONDITION lost. <b>Right Lung ATELECTASIS</b> <b>CARCINOMA of the Lung</b> <b>WIDE SPREAD METASTASIS</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>II</b>			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9-9 1972</b> to <b>9-28 1972</b> , that (I) (we) last saw the deceased alive on <b>9-28 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Luis Sirotzky</b>		23B. DATE SIGNED <b>9/28/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>LUIS SIROTZKY</b>		23D. ADDRESS <b>H. D. UNION MEMORIAL HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/2/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Parkwood Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 29 1972</b>		25B. NAME OF REGISTRAR <b>Andrew [Signature]</b>	
25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc.</b>		ADDRESS <b>5305 Harford Road 21211</b>	

X

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-360 72 09311		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09311	
Frederick (Fred) John Ritter					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print)		Ritter, Fred J.		2. DATE AND HOUR OF DEATH 9-27-72 8:50 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY		STATE OF MARYLAND - DEHE	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		MARYLAND		2706	
CHURCH HOME & HOSPITAL		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
35		E. STREET AND NUMBER 2204 HAMILTON AVE.			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 04-14-96	9. AGE (In years last birthday) 76	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Government Auditor		10B. KIND OF BUSINESS OR INDUSTRY Customs		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME LOUES AELSON RITTER.		14. MOTHER'S MAIDEN NAME Selma Fiedler		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W W II		16. SOCIAL SECURITY NO. 120-32-3509		17. INFORMANT NELSON RITTER.	
18. 250.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CVA.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic heart disease.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: diabetes mellitus.			
(C)					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-26 1972 to 9-27 1972 that (I) (we) last saw the deceased alive on 9-26 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jung Ho Kim M.D.		23B. DATE SIGNED 9-27-72		23C. PHYSICIAN'S NAME (Type) JUNG-HO KIM, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/30/72		24C. NAME OF CEMETERY or CREMATORY Oaklawn Cemetery	
25A. DATE REC'D BY HEALTH DEPT. SEP 29 1972		25B. NAME OF REGISTRAR Sidney Whitton		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. 5305 Harford Rd.	
24D. LOCATION (City, town, or county) Baltimore Maryland		24E. LOCATION (City, town, or county) Baltimore Maryland		24F. LOCATION (City, town, or county) Baltimore Maryland	

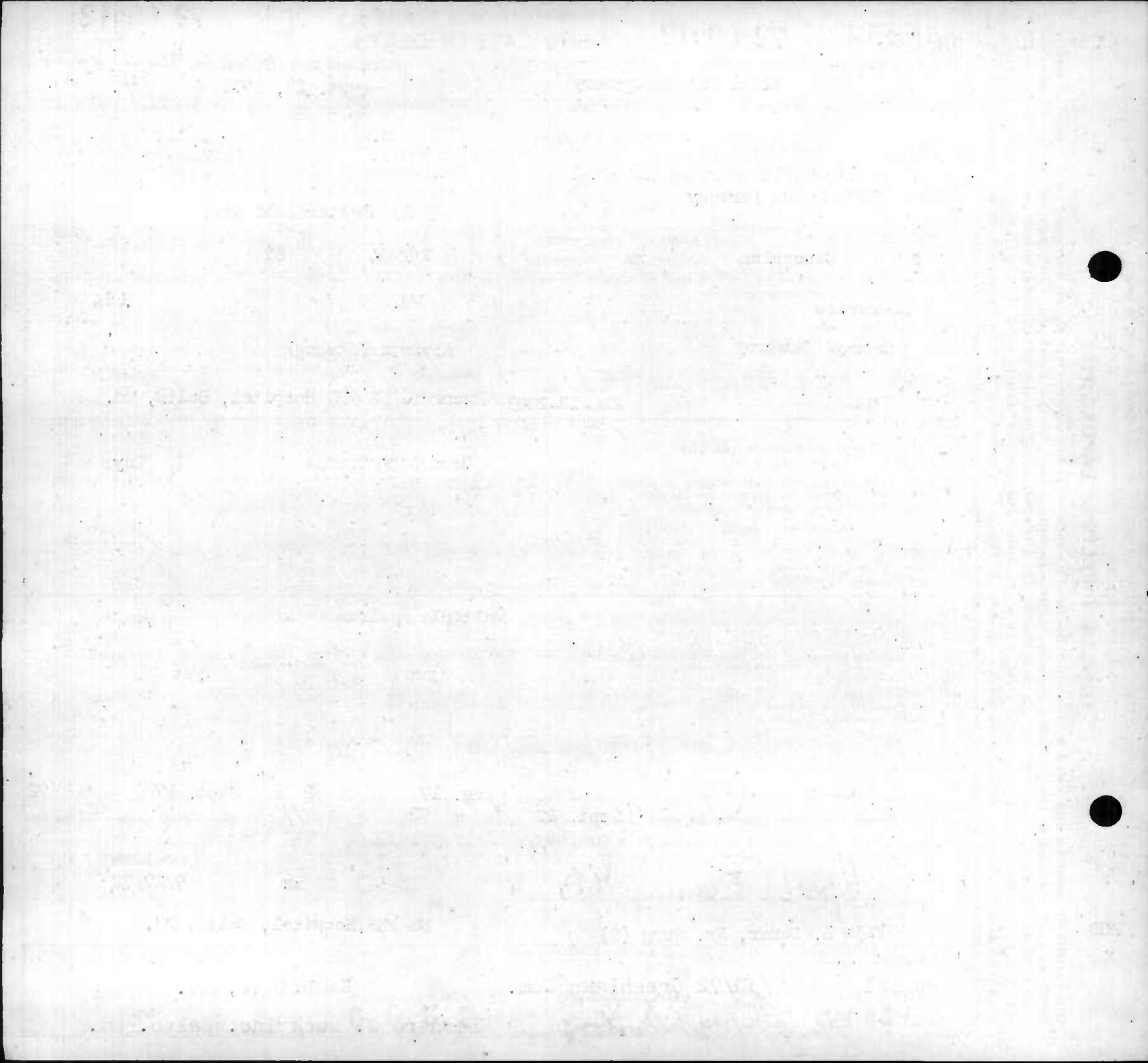


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09312	
M-532 72 09312				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH STATE OF MARYLAND - DEATH	
		Ethel Mae Montgomery		Sept. 27, 1972 7:55 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION US Public Health Service Hospital 3100 Wyman Parkway			A. STATE Md. B. COUNTY		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
2X			E. STREET AND NUMBER 3925 Chesterfield Ave.		
5. SEX F	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/3/04	9. AGE (In years last birthday) 68	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME George Mowbray		14. MOTHER'S MAIDEN NAME Alverta Fitzhugh		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-12-2093		17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 485 XI + 203X Bronchopneumonia			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			Multiple myeloma Months		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug. 17 1972 to Sept. 27 1972, that (I) (we) last saw the deceased alive on Sept. 27 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Vija L. Bauer, M.D.				23B. DATE SIGNED 9/27/72	
23C. PHYSICIAN'S NAME (Type) Vija L. Bauer, Sr. Surg (R)				23D. ADDRESS US PHS Hospital, Balto, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/30/72		24C. NAME OF CEMETERY or CREMATORY Greenlawn Cem.	
25A. DATE REC'D BY HEALTH DEPT. SEP 29 1972		25B. NAME OF REGISTRAR Sidney W. Horton		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md.	
24D. LOCATION (City, town, or county) (State)		24E. LOCATION (City, town, or county) (State)			
Cambridge, Md.		Cambridge, Md.			



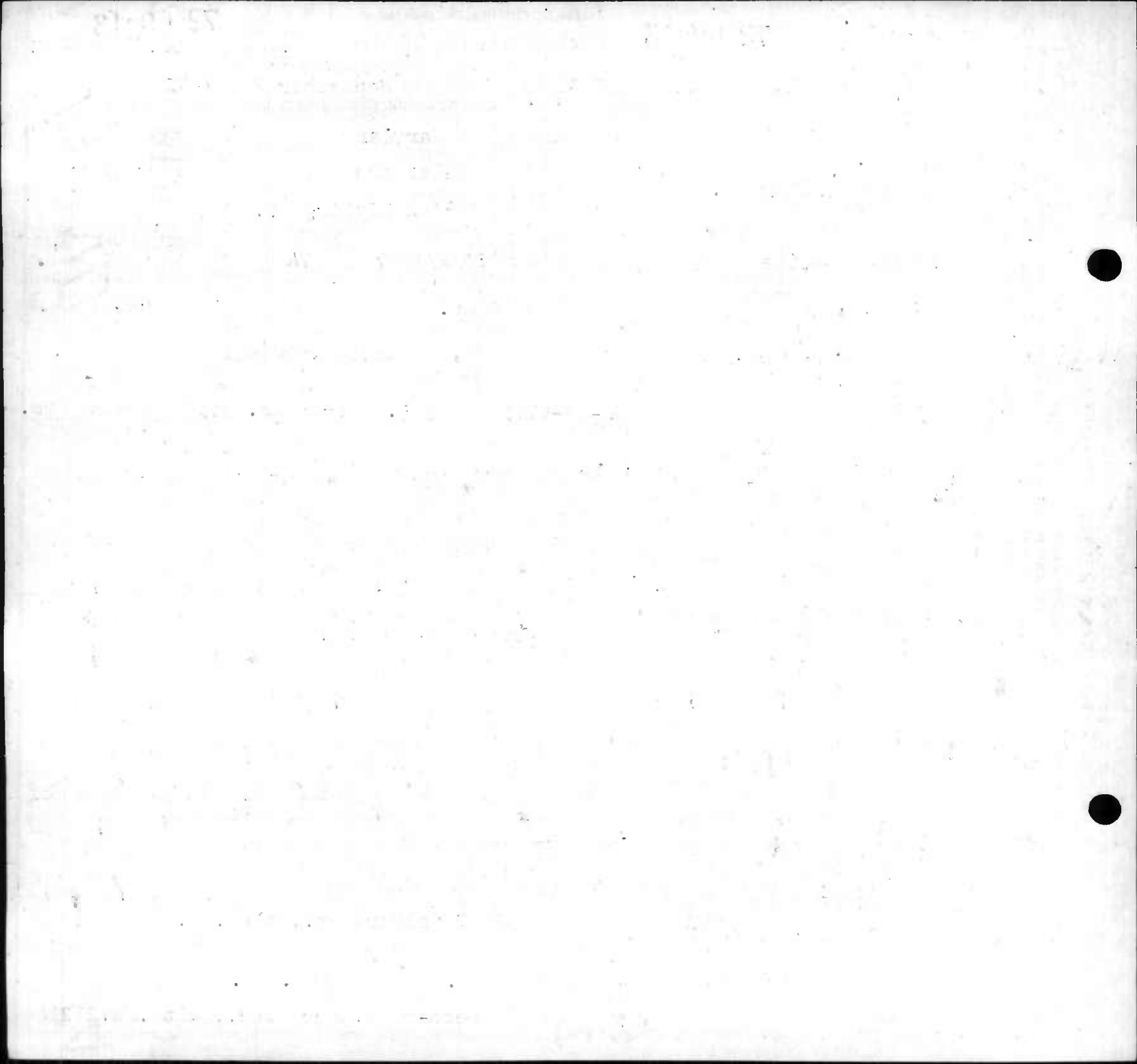


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <b>72 09313</b> STATE OF MARYLAND-DEATH
BIRTH NO. <b>K-656</b>		72 09313		
1. NAME OF DECEASED (Type or Print) <b>LILLIAN M. KARNER</b>		2. DATE AND HOUR OF DEATH <b>September 27, 1972 6<sup>15</sup> A. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>5802 Kipling Ct.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2778</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>5802 Kipling Ct.</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/2/1897</b>	9. AGE (In years last birthday) <b>74</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>John Smith</b>		
14. MOTHER'S MAIDEN NAME <b>Annie Kowalski</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		
16. SOCIAL SECURITY NO. <b>220-44-6775</b>		17. INFORMANT <b>Ralph E. Karner Jr.</b> ADDRESS <b>5559 Cedonia Ave.</b>		
18. <b>410.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Myocardial infarction</b> (B) <b>Coronary arteriosclerosis</b> (C) <b>Hypertension</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b> <b>10 yrs</b> <b>10 yrs</b>		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>Oct 26 1965</b> to <b>Sept 27 1972</b> that (I) (we) last saw the deceased alive on <b>Sept 27 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Stephen J Van Lill MD</b>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <b>Stephen VanLill</b>
23D. ADDRESS <b>3502 Calvert St., Balto. Md.</b>		23E. PHYSICIAN'S DEGREE		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/30/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>
24D. LOCATION (City, town, or county) <b>Balto. Md.</b>		24E. STATE (State)		
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 29 1972</b>		25B. NAME OF REGISTRAR <b>Audrey Johnston</b>		25C. FUNERAL DIRECTOR (Address) <b>Leonard J. Ruck Inc., Balto. Md. 21214</b>

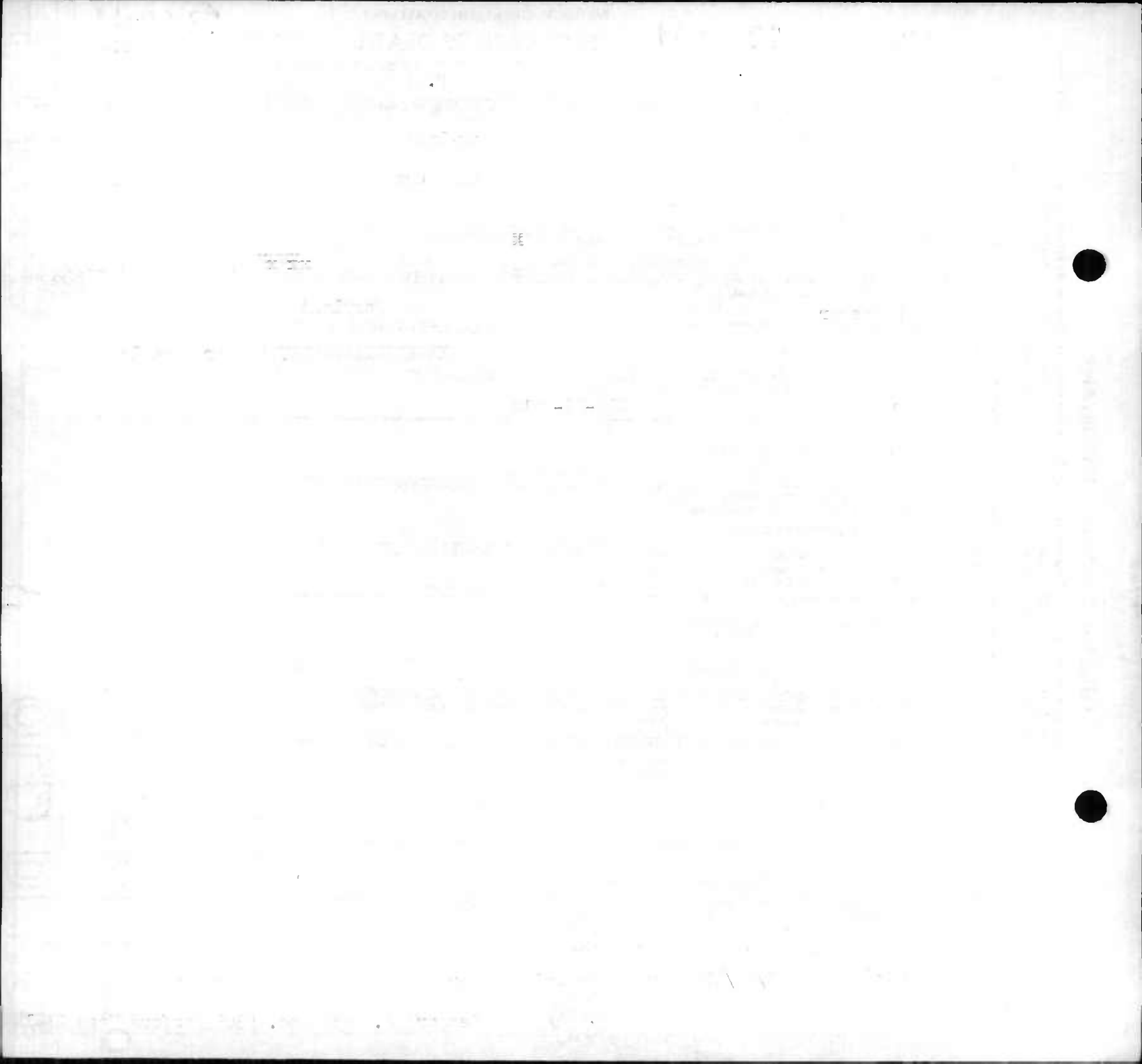




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

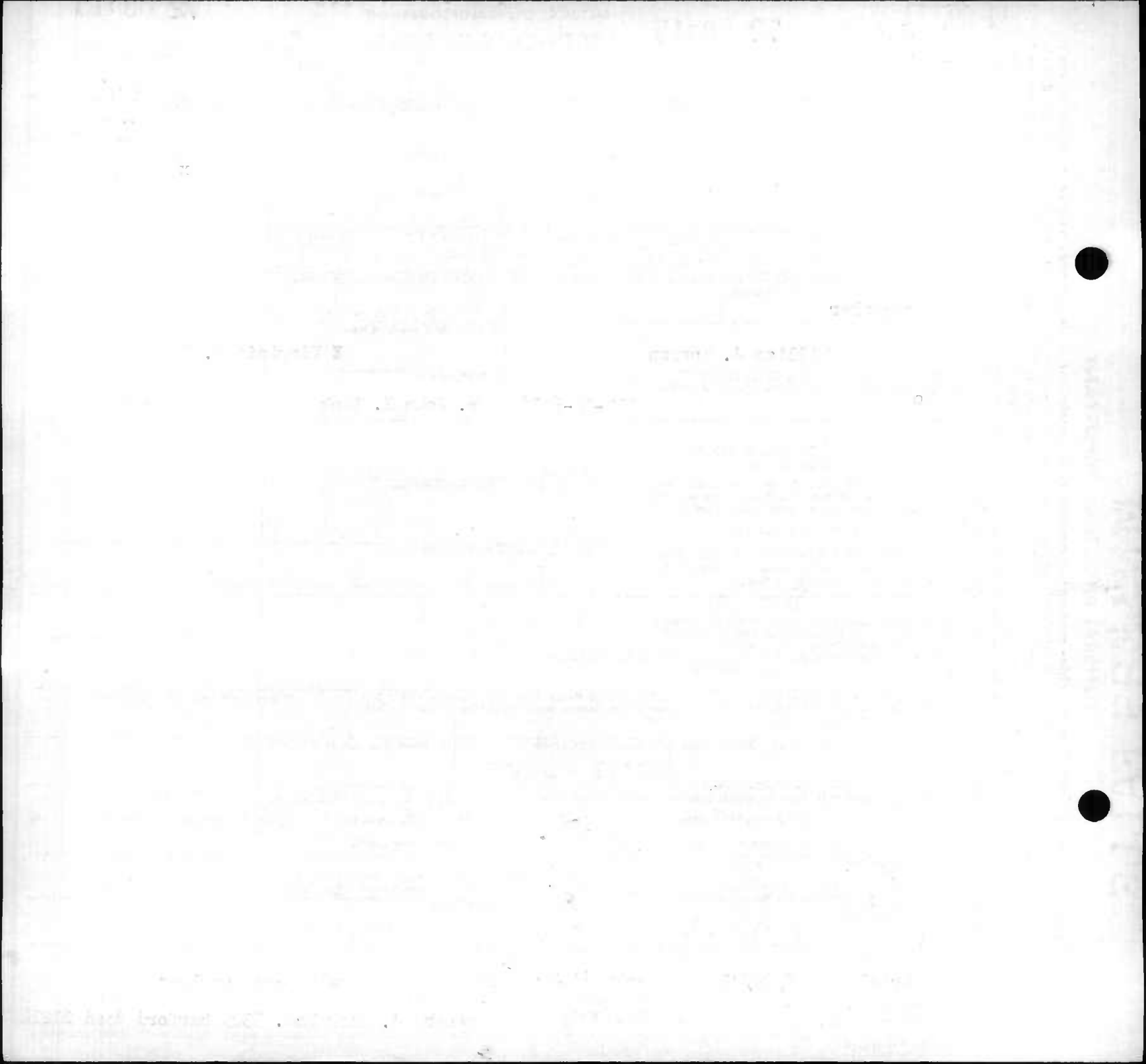
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 09214</b>	
BIRTH NO. <b>4-100</b>				STATE OF MARYLAND - DEATH	
72 09214				DATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>HEAPHY LEO P.</b>		2. DATE AND HOUR OF DEATH <b>9/28/72 4:30 AM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>UNION MEMORIAL HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2733</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSPITAL</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>MALE</b>		6. RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>12/26/86</b>		9. AGE (In years last birthday) <b>85</b>		10. UNDER 1 Yr. Months Days 11. UNDER 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Book Keeper</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>PATRICK HEAPHY</b>		14. MOTHER'S MAIDEN NAME <b>Mary Crowley</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <b>No</b>		16. SOCIAL SECURITY NO. <b>219-07-9618</b>		17. INFORMANT ADDRESS <b>FRANCIS HEAPHY 1634 NODDING AVE</b>	
18. <b>285.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>DEHYDRATION, ANEMIA</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>Dr. C. RUFER</b> (this hospital) attended the deceased from <b>9/26/72</b> to <b>9/28/72</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>9/27/72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Dr. C. RUFER</b>		23B. DATE SIGNED <b>9/28/72</b>			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/30/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>	
24D. LOCATION <b>Baltimore Maryland</b>					
25A. DATE RECEIVED BY HEALTH DEPT. <b>SEP 29 1972</b>		25B. NAME OF REGISTRAR <b>Leonard J. Ruck Inc.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>5305 Harford Road 21214</b>	



# FUNERAL DIRECTOR: IMPORTANT

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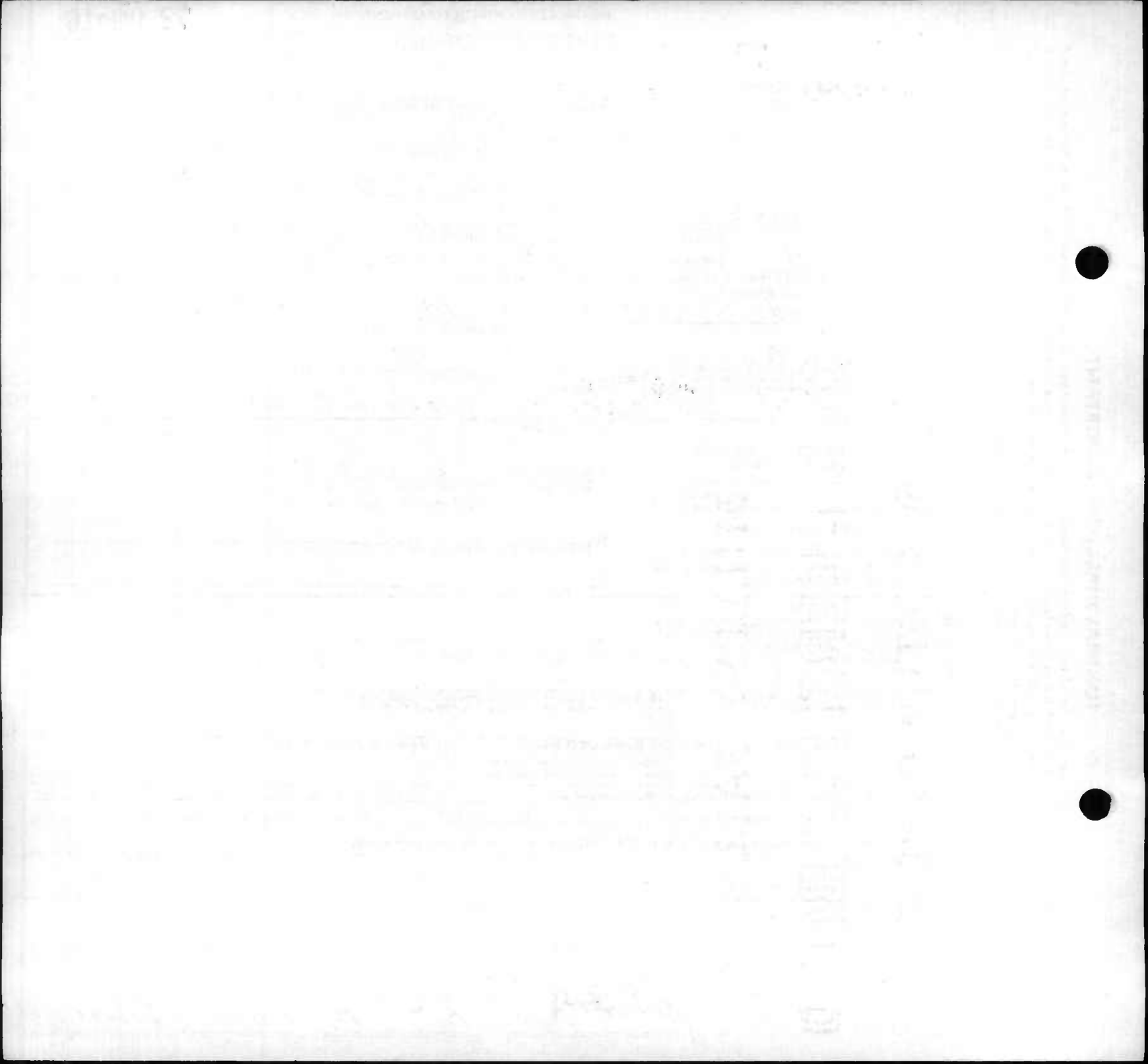
BALTIMORE CITY HEALTH DEPARTMENT CITY OF BALTIMORE				REG. NO. STATE OF MARYLAND - DHHS	
1. NAME OF DECEASED (Type or Print) <u>Grace O. Link</u>		2. DATE AND HOUR OF DEATH <u>9/28/72</u> <u>8:45</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Maryland General Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>21214</u> C. CITY OR TOWN <u>Balto</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3029 Weaver Ave</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/20/00</u>	9. AGE (In years last birthday) <u>72</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William J. Morgan</u>		14. MOTHER'S MAIDEN NAME <u>Virginia N. Pusey</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-34-5036</u>		17. INFORMANT <u>Mr. John H. Link</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>038.1</u> <u>Pneumonia</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Intestinal Obstruction</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Staphylococcus septicemia</u> (C) <u>+ ? bacterial endocarditis</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>9/22</u> 19 <u>72</u> to <u>9/28</u> 19 <u>72</u> that (I) <u>(we)</u> last saw the deceased alive on <u>9/28</u> 19 <u>72</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <u>William R. Davidson Jr. M.D.</u>				23B. DATE SIGNED <u>9/28/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>William R. Davidson Jr. M.D.</u>				23D. ADDRESS <u>Maryland General Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/30/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Parkwood Cemetery</u>	
24D. LOCATION <u>Baltimore Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 29 1972</u>			
25B. NAME OF REGISTRAR <u>Lidney Ingham</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Rack Inc. 5305 Harford Road 21214</u>			



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BALTIMORE CITY HEALTH DEPARTMENT				72 09216		REG. NO.	
BIRTH NO.				72 09216			
1. NAME OF DECEASED <i>MARY MADELINE PHILLIPS</i>				2. DATE AND HOUR OF DEATH <i>9-27-72 11:25 A.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>34 Bon Secours Hospital</i>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>1902</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>34 Bon Secours Hospital</i>				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <i>1321 W. Lemmon ST. 21223</i>			
5. SEX <i>F</i>	6. RACE <i>B</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-25-02</i>	9. AGE (In years last birthday) <i>69</i>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unemployed. DOMESTIC</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>MD., Newport</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Chase</i>				14. MOTHER'S MAIDEN NAME <i>Martha Ford</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>				16. SOCIAL SECURITY NO. <i>712-32-3731</i>		17. INFORMANT <i>Donald A. Chase 250 NIMMON RD #4</i>	
18. CAUSE OF DEATH <i>151.91</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>UNKNOWN</i>			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>CARCINOMA OF STOMACH with METASTASES to Liver.</i>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>-</i>		20A. AUTOPSY (Yes or No) <i>yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>-</i>		21C. WHERE OLD INJURY OCCURRED (If in Baltimore City, give exact location) <i>-</i>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>-</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>-</i>			
22. I certify that (I) (this hospital) attended the deceased from <i>19/9/1972</i> to <i>27/9/1972</i> that (I) (we) last saw the deceased alive on <i>27/9/1972</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Charlan Ungbhakorn M.D.</i>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>9/27/72</i>	
23C. PHYSICIAN'S NAME (Type) <i>CHARLAN UNGBHAKORN M.D.</i>				23D. ADDRESS <i>BON SECOURS HOSP., 2025 W. FAYETTE ST., BALTIMORE MD. 21223</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9/29/72</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Not known</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore MD</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 29 1972</i>				25C. FUNERAL DIRECTOR <i>W. J. Hayes 638 N. Gilman St</i>			





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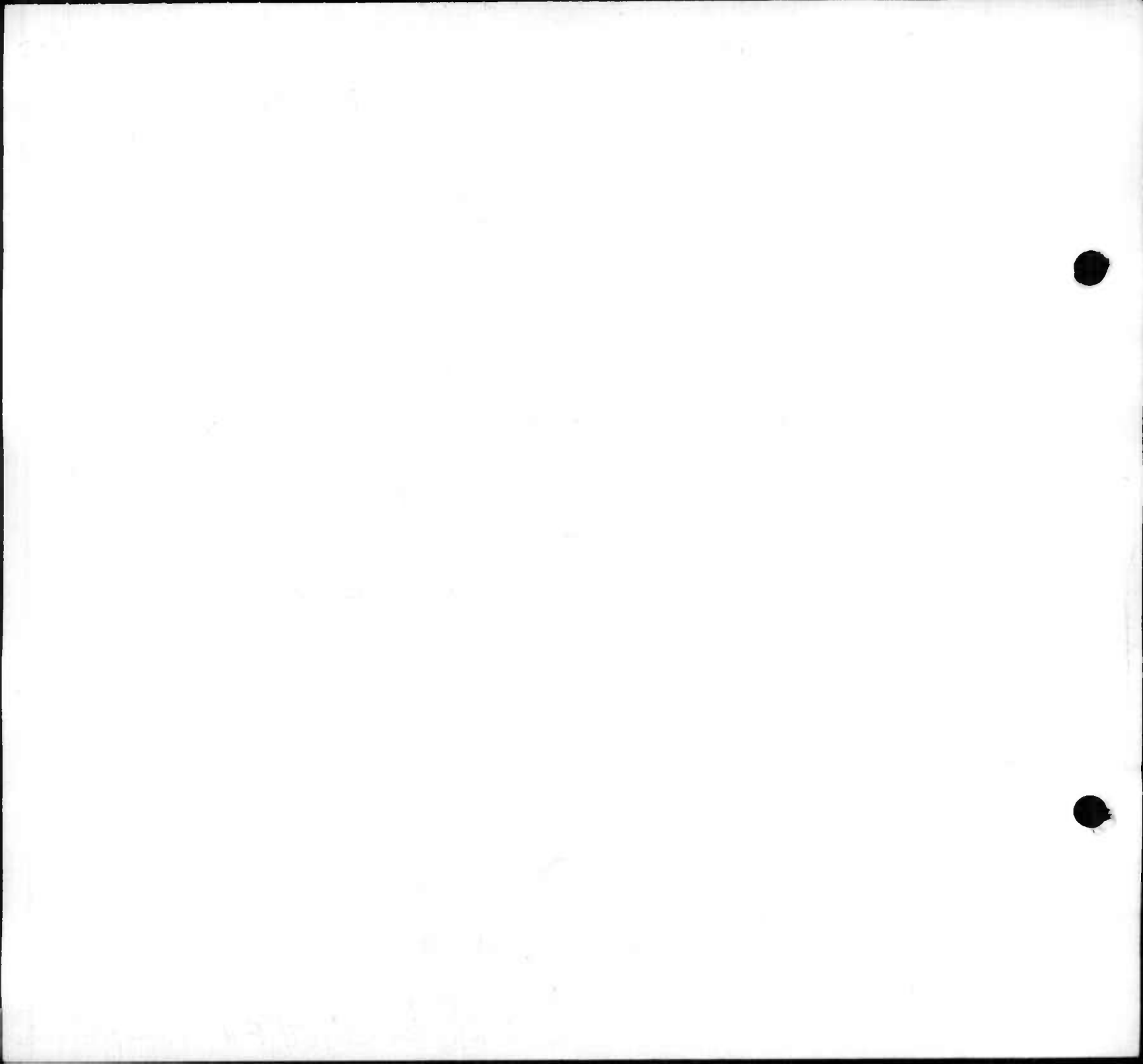
STATE OF MARYLAND				BALTIMORE CITY HEALTH DEPARTMENT			
B-650 72 09217				72 09217			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO.			
BIRTH NO. 72-03255							
1. NAME OF DECEASED (Type or Print) LASHAWN BROWN				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour September 28, 1972 M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital				3. DATE PRONOUNCED DEAD Month Day Year Hour September 28, 1972 11:15 A. M.			
5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) A. STATE Maryland B. COUNTY 2802							
6. SEX Female	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 3-2-72		10. AGE (In years last birthday) 7		E. STREET AND NUMBER 5511 Belleville Avenue			
11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF U.S.A.		13. FATHER'S NAME MACK BROWN			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME PATRICIA DUCKETT			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. INFANT		18. INFORMANT ADDRESS PATRICIA DUCKETT 5511 BELLEVILLE AVE.			
19. E 988 X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE Subdural hematoma DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? ?			
22D. TIME OF INJURY (APPROX.) ? (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? ?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>  ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> M.D. Deputy Chief Medical Examiner <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. Assistant Medical Examiner <input type="checkbox"/> DATE SIGNED September 28, 1972 Associate Medical Examiner <input type="checkbox"/>							
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9-30-72		24C. NAME of CEMETERY or CREMATORY WOODLAWN CEMETERY		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. SEP 29 1972		25B. NAME OF REGISTRAR Sidney [Signature]		25C. FUNERAL DIRECTOR ADDRESS MORTON & DYETT F. H. 1701 LAURENS ST.			



# FUNERAL DIRECTOR: IMPORTANT

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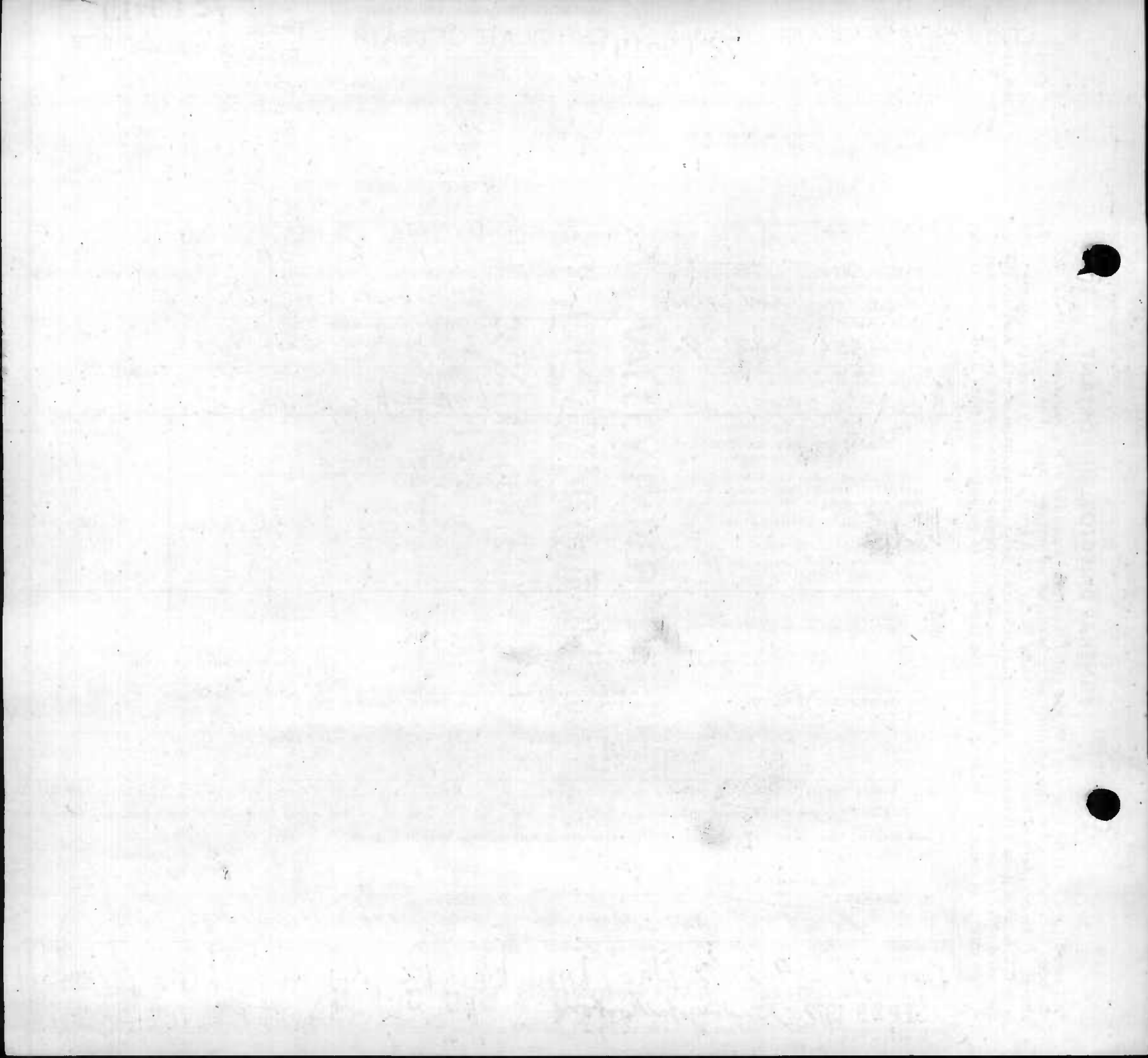
W-452		72 09218		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09218	
BIRTH NO.		CERTIFICATE OF DEATH				STATE OF MARYLAND-DUMM	
1. NAME OF DECEASED (Type or Print) <u>Williams, Richard L.</u>				2. DATE AND HOUR OF DEATH <u>9/27/72</u> <u>12:30</u> P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>U. of Md. Hospital</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1801</u>			
				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>116 N. Poppleton</u>			
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-3-44</u>	9. AGE (In years lost birthday) <u>28</u>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A. - Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Willie Williams</u>				14. MOTHER'S MAIDEN NAME <u>Ernestine Kirk</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-44-1947</u>		17. INFORMANT <u>Ernestine Moeagan</u>		ADDRESS <u>116 - Poppleton St</u>	
18. <u>038.91 + 303.2</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF:  (B) <u>Irreversible Hypertension, Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF:  (C) <u>Sepsis, Previous Arrest</u> <u>3 days</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>By history - Chronic alcoholism</u>							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>9-24</u> 19 <u>72</u> to <u>9-27</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>9-27</u> 19 <u>72</u> and that in (my) (our) opinion a death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Carl R. Garry M.D.</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>9-27-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. Gallorway</u>				23D. ADDRESS <u>U. of Maryland Hospital</u>			
24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-2-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Alt. Auburn Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 29 1972</u>		25B. NAME OF REGISTRAR <u>Sidney Whitman</u>		25C. FUNERAL DIRECTOR <u>Morton Dyett F.H.</u>		ADDRESS <u>1701 - Laurens St</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 69219	
J-525				72 09219	
BIRTH NO.				72 09219	
1. NAME OF DECEASED (Type or Print) <b>GEORGE R. JOHNSON</b>			2. DATE AND HOUR OF DEATH <b>SEPTEMBER 25th 1972 2.20 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSPITAL</b> <b>44</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>U.S.A.</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>4430 WRENWOOD AVENUE, B1</b>		
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>03-15-22</b>	9. AGE (In years last birthday) <b>50</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GENERAL HOMEWOMAN IMPROV.</b>			11. BIRTHPLACE (State or foreign country) <b>S. CAROLINA, Foxevoston</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>ISRAEL JOHNSON</b>			14. MOTHER'S MAIDEN NAME <b>ELLEN MATTHEWS</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 10-28-42-12-23-43</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>EVA Johnson-4430-Wrenwood Ave</b>
18. <b>410.91</b>			CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <b>CARDIOGENIC SHOCK</b> <b>2 DAYS</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>MID CARDIAL INFARCTION</b> <b>3 DAYS</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>09-22-1972</b> to <b>09-25-1972</b> , that (I) (we) last saw the deceased alive on <b>09-25-1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Franklin to Dwyer</b>				23B. DATE SIGNED <b>9/25/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>CARLOS H. SANTILLAN, M.D.</b>				23D. ADDRESS <b>THE UNION MEMORIAL HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-29-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Maryland Valley Park Laurel, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 29 1972</b>		25B. NAME OF REGISTRAR <b>Andrew Johnson</b>		25C. FUNERAL DIRECTOR <b>Marlow &amp; Dyett F.H.</b>	
				ADDRESS <b>1701-1705 St.</b>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO. 72-09320

72 09320

1. NAME OF DECEASED (Type or Print) <b>Lester Jackson</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>9 18 72 9:45 P. M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Provident Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>9 18 72 9:45 P. M.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2798</b>	
9. DATE OF BIRTH <b>5-29-72</b>		10. AGE (In years last birthday) <b>4</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT		ADDRESS	
19. <b>795X1</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Marvin S. Platt</u> M.D. EXAMINER'S NAME (Type) <u>Marvin S. Platt, M.D.</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>9-19-72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>cremation</b>		24B. DATE <b>9-26-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Med. Ex. Office</b>		24D. LOCATION (City, town, or county) (State) <b>111 Penn St. Balt MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 29 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Johnston</b>	
25C. FUNERAL DIRECTOR <b>MORTUARY SERVICE - BCHD</b>		ADDRESS	



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STATE OF MARYLAND - DEPT  
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 72 09321

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CLEVELAND BROWN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> September 10, 1972 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour September 10, 1972 7:30 A.M.	
6. SEX Male	7. RACE Negro	5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2798	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 8-26-72		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years lost birthday)	11. BIRTHPLACE (State or foreign country)	E. STREET AND NUMBER 502 Elmer Avenue	
12. CITIZEN OF WHAT COUNTRY?	13. FATHER'S NAME	14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME Andrew Taylor	16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		
17. SOCIAL SECURITY NO.	18. INFORMANT ADDRESS 5002 Elmer Ave		
19. 795X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Sudden death in infancy DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2	20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>  ACTUAL SIGNATURE <u>Marvin S. Platt, M.D.</u> M.D. EXAMINER'S NAME (Type) Marvin S. Platt, M.D.  DATE SIGNED 9/10/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation	24B. DATE 9-26-72	24C. NAME OF CEMETERY OR CREMATORY Med Ex Office	24D. LOCATION (City, town, or county) (State) 111 Penn. St. Baltimore, Md.
25A. DATE REC'D BY HEALTH DEPT SEP 29 1972	25B. NAME OF REGISTRAR A. S. H. H. H.	25C. FUNERAL DIRECTOR ADDRESS MORTUARY SERVICE - BCHD	

VS 151-REV. 1/1/68

5002 Elmer Ave.  
Sinai Hosp.

10-10-1972 - Completion of cause of death on a pending medical examiner death certificate  
Marvin S. Platt, M.D. HRS

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 09322</b>
G-125 72 09322 <b>CERTIFICATE OF DEATH</b>				STATE OF MARYLAND - DEPT. OF HEALTH
BIRTH NO. <b>G-125</b>		1. NAME OF DECEASED (Type or Print) <b>Gibson, Charles</b>		
2. DATE AND HOUR OF DEATH <b>09-26-72 1:00 P. M.</b>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>909</b>		FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205</b>		
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-17-02</b>	9. AGE (In years last birthday) <b>69</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Baltimore Dept</b>		11. BIRTHPLACE (State or foreign country) <b>Va.</b>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>RANDY GILLIS</b>		
14. MOTHER'S MAIDEN NAME <b>MELVINA GIBSON</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES Aug 19, 1950 - May 26, 1952</b>		
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Lillian Gibson 1408 N. Central Ave</b>		
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CARDIAC ARREST</b>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>RESPIRATORY ARREST</b>				<b>2 min</b>
(C) <b>Carcinoma of R Lung &amp; metastases</b>				<b>6 mo</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Hypercalcemia</b>				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21F. HOW DID INJURY OCCUR?
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from <b>September 18 1972</b> to <b>September 26 1972</b> , that (I) (we) last saw the deceased alive on <b>September 26 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Douglas J. Deutsch</b>				23B. DATE SIGNED <b>9-26-72</b>
23C. PHYSICIAN'S NAME (Type) <b>DOUGLAS J. DEUTSCH</b>		23D. ADDRESS <b>M.D. THE JOHNS HOPKINS HOSPITAL</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/29/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Arturum Mem PK</b>
24D. LOCATION (City, town, or county) <b>Arturum Md.</b>		(State)		
25A. DATE RECEIVED BY HEALTH DEPT. <b>SEP 29 1972</b>		25B. NAME OF REGISTRAR <b>Lillian Gibson</b>		25C. FUNERAL DIRECTOR <b>Joseph E. Lockridge 1304 N. Central Ave</b>

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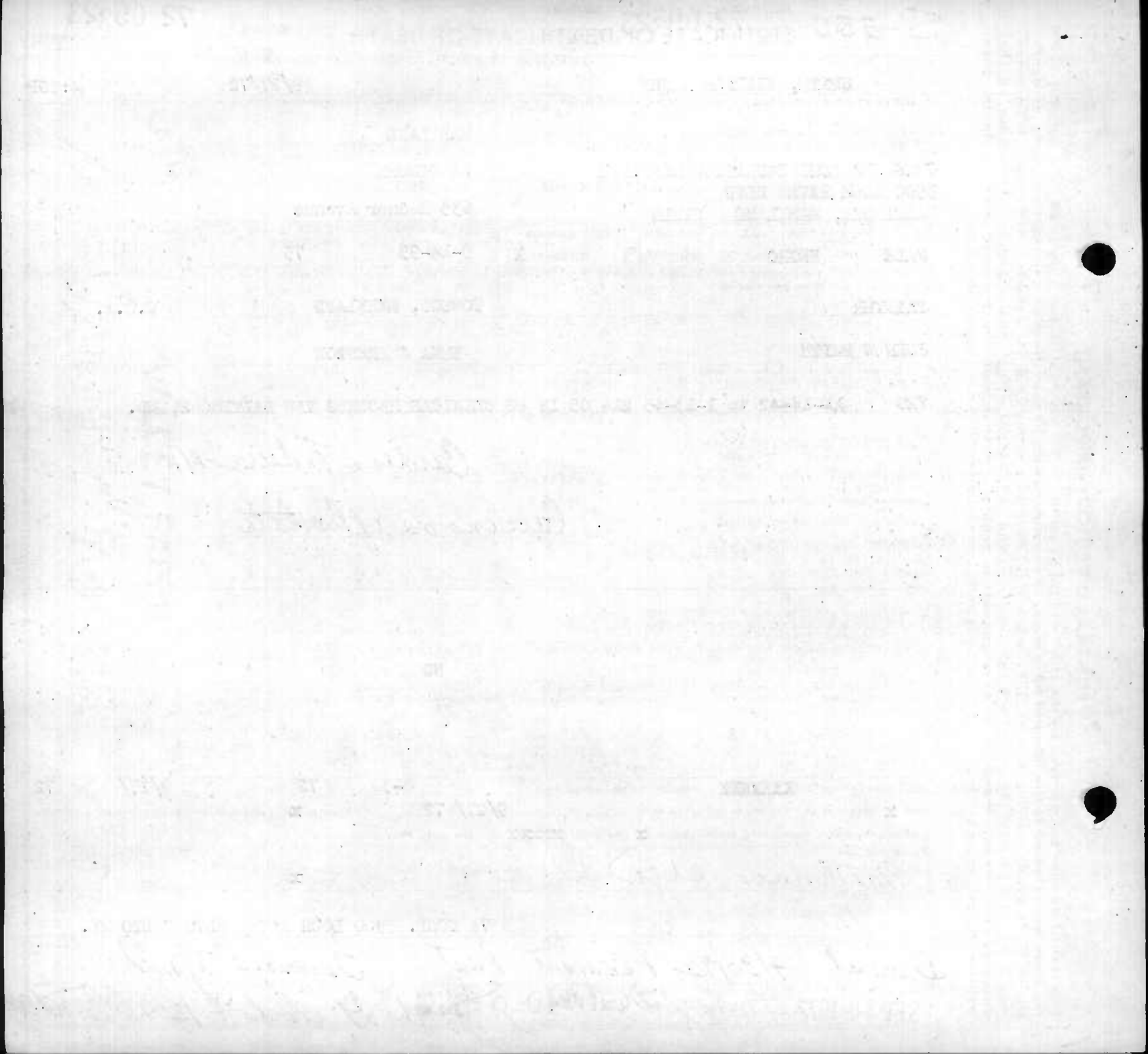
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span style="font-size: 2em;">S-530</span> <span>72 09323</span> </div>		<div style="display: flex; justify-content: space-between;"> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> <span>72 09323</span> </div>	
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO.</span> <span>CERTIFICATE OF DEATH</span> </div>		<div style="display: flex; justify-content: space-between;"> <span>REG. NO.</span> <span>STATE OF MARYLAND-DEATH</span> </div>	
1. NAME OF DECEASED (Type or Print) <b>SMITH, WILLIAM HENRY</b>		2. DATE AND HOUR OF DEATH <b>9/27/72 4:20P.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2710</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>VETERANS ADMINISTRATION HOSPITAL</b>		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>3900 LOCH RAVEN BLVD</b>		E. STREET AND NUMBER <b>635 Radnor Avenue</b>	
<b>BALTIMORE, MARYLAND 21218</b>			
5. SEX <b>MALE</b>	6. RACE <b>NETRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>9-14-99</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PAINTER</b>		9. AGE (In years last birthday) <b>75</b>	11. BIRTHPLACE (State or foreign country) <b>TOWSON, MARYLAND</b>
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN W SMITH</b>		14. MOTHER'S MAIDEN NAME <b>EMMA J PRESTON</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES 11-14-42 to 1-13-45</b>		16. SOCIAL SECURITY NO. <b>216 05 18 80</b>	
17. INFORMANT		ADDRESS <b>CLINICAL RECORDS VAH BALTIMORE, MD.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardiac Failure - MI</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>?</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Carcinoma of Prostate</b>		<b>?</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>8-30-72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NO</b>	
20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>NO</b>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>did not</del> ) attended the deceased from <b>8-30-72</b> to <b>9/27/72</b> , that (I) (we) lost saw the deceased alive on <b>9/27/72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) ( <del>did not</del> ) view the body after death.			
23A. SIGNATURE <i>William Henry Smith</i>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <i>William Henry Smith</i>		23D. ADDRESS <b>VA HOSP. 3900 LOCH RAVEN BLVD BALTO MD.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/30/72</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Pleasant Rest</b>		24D. LOCATION (City, town, or county) (State) <b>Towson, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 29 1972</b>		25B. NAME OF REGISTRAR <i>Joseph J. Locke</i>	
25C. FUNERAL DIRECTOR <i>Joseph J. Locke</i>		ADDRESS <b>1304 N. Central St.</b>	







## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 09324

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Dorothy Clark		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 9 27 72 5:55P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 9 27 72 5:55P. M.		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1604	
6. SEX Female	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH 12/16/39	10. AGE (in years last birthday) 32	11. BIRTHPLACE (State or foreign country) Maryland	E. STREET AND NUMBER 1801 Loretta Avenue		
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Thomas Stukes			
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME Evelyn Beale			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.		18. INFORMANT Evelyn Beale	
19. CAUSE OF DEATH		ADDRESS 813 Brooks Lane			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Fatty liver DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C)			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Marvin S. Platt, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9-28-72	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	10-27-72	Not Burial Crem		Westport Md	
25A. DATE RECEIVED BY HEALTH DEPT.	25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS		
SEP 29 1972	1972 2000		Charles H. Rice 1300 Eastern		

1801 LAURETTA

S-530

72 09325 STATE OF MARYLAND - DEPT. OF HEALTH  
BALTIMORE CITY HEALTH DEPARTMENT

72 09325

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>ANTOINETTE SMITH</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>130 N. Asquith St. Apt. 1C</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>9 20 1972 12:55p</b> M.	
6. SEX <b>female</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE <b>negro</b>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>8/30/50</b>		10. AGE (In years last birthday) <b>22</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. <b>219-52-6633</b>	
18. INFORMANT <b>Mrs. Bessie Moore, mother, 3512 Woodland Ave.</b>		ADDRESS <b>Balto., Md.</b>	
19. <b>304.9</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE <b>Intravenous narcotism</b> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2-25-72</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b> M.D. EXAMINER'S NAME (Type) DATE SIGNED <b>9-20-72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-25-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt Auburn</b>		24D. LOCATION (City, town, or county) (State) <b>Westport Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 29 1972</b>		25B. NAME OF REGISTRAR <b>Sidney H. [Signature]</b>	
25C. FUNERAL DIRECTOR <b>Charles A. Rice</b>		ADDRESS <b>1300 E. [Signature]</b>	

10-5-1972 - Letter from the Office of the Chief Medical Examiner, Russell S. Fisher, M.D.  
Chief Medical Examiner HRS

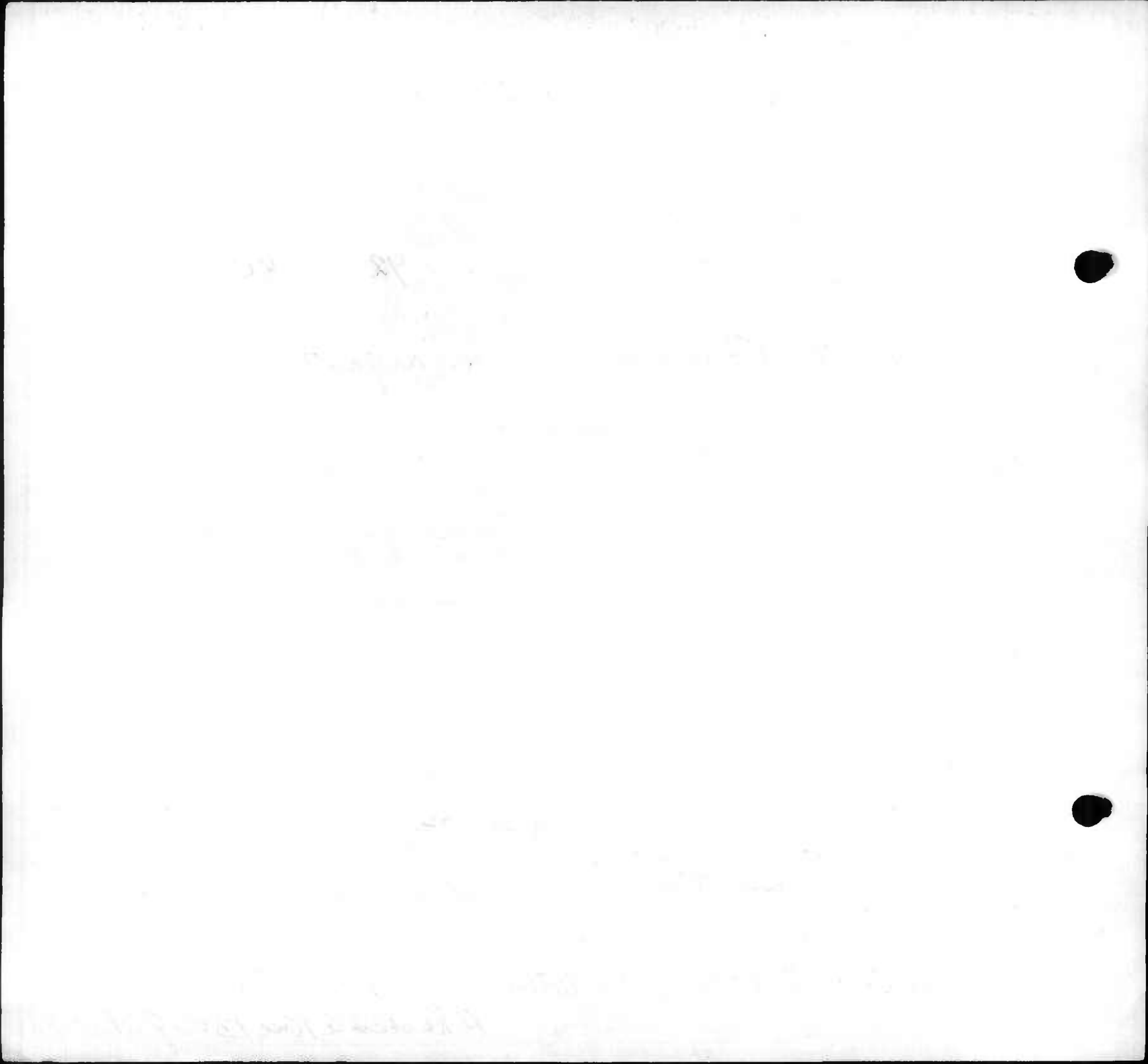
10/10/72 - Correction form from funeral director.

*LFC*

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-120		72 09326		BALTIMORE CITY HEALTH DEPARTMENT		72 09326	
BIRTH NO.				REG. NO. STATE OF MARYLAND-DHMH			
1. NAME OF DECEASED (Type or Print) <b>Gibbs, Lizzie ELIZABETH</b>				2. DATE AND HOUR OF DEATH <b>Sept. 23, 1972 12:35 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived; If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <b>Maryland</b>		B. COUNTY <b>2543</b>	
<b>Provident Hospital, Inc.</b>		<b>2600 Liberty Hgts. Ave.</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>F</b>		6. RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-10-92</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <b>80</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
13. FATHER'S NAME <b>Robert Cowan</b>				14. MOTHER'S MAIDEN NAME <b>Margaret</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>42-82-3503</b>		17. INFORMANT <b>Elizabeth Brown</b>		ADDRESS <b>21230 2415 Puget St</b>	
18. <b>1241</b> DISEASE OR CONDICTION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>AC. CEREBROVASCULAR ACCIDENT</b> ANTECEDENT CAUSES DISEASES OR CONDICTIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ARTERIOSCLEROTIC C-V DIS</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDICTION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>9/1/1972</b> to <b>9/23/1972</b> that (I) (we) last saw the deceased alive on <b>9/23/1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>John S. Braxton Jr.</b>				23B. DATE SIGNED <b>9/23/72</b>		23C. PHYSICIAN'S NAME (Type) <b>JOHN S. BRAXTON JR.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/29/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Charlotte</b>		24D. LOCATION (City, town, or county) (State) <b>Charlotte, N.C.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 29 1972</b>		25B. NAME OF REGISTRAR <b>Andrew Winston</b>		25C. FUNERAL DIRECTOR <b>Charles A. Rice</b>		ADDRESS <b>1300 Entwour Ph.</b>	

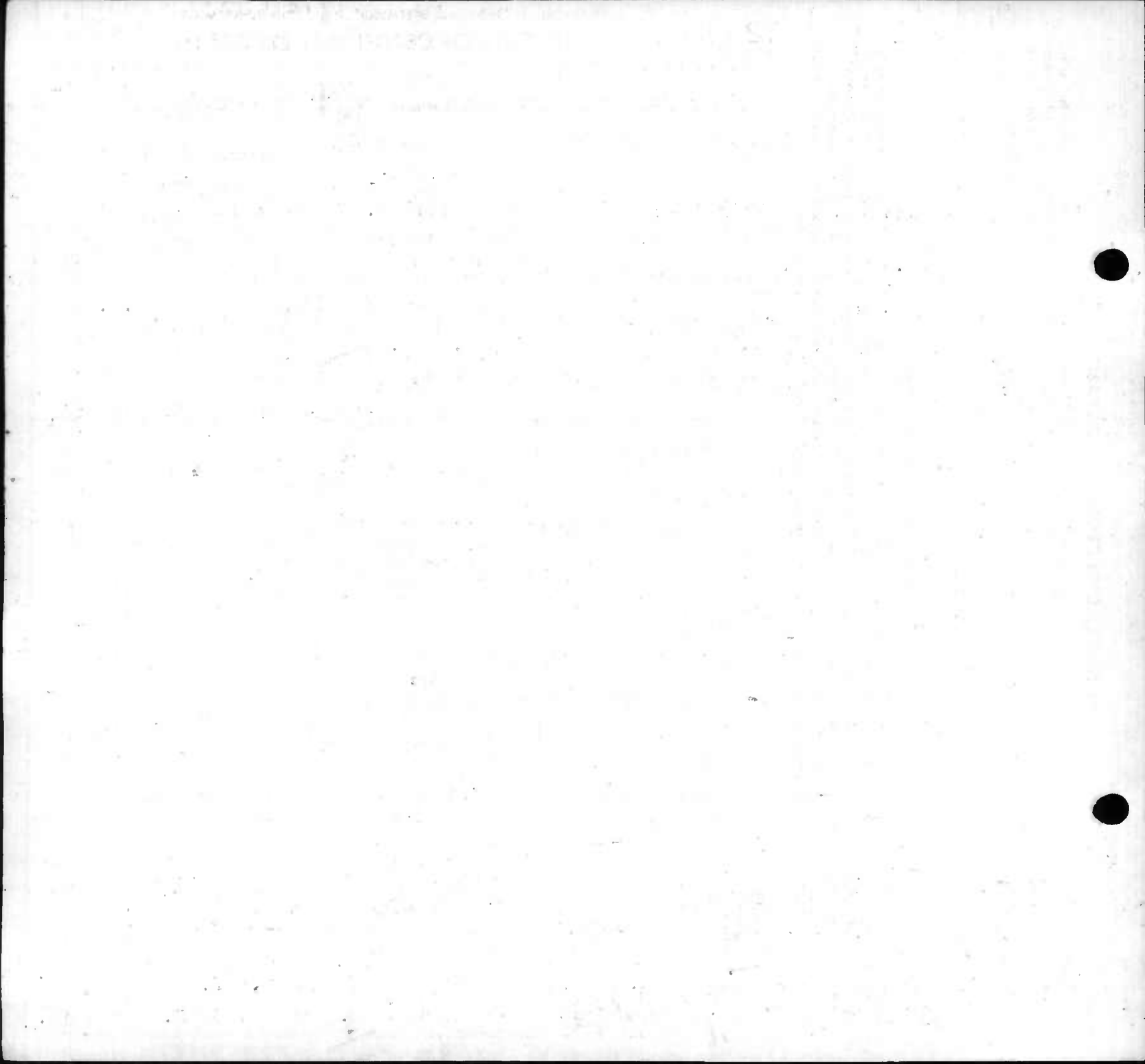


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72-09327		72-09327	
BIRTH NO.				72-09327		STATE OF MARYLAND-DEATH	
1. NAME OF DECEASED (Type or Print) <u>Lyda Adams</u>				2. DATE AND HOUR OF DEATH <u>9/26/72</u> <u>1:39</u> <u>00</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>00</u>				A. STATE <u>Maryland</u> B. COUNTY <u>1601</u>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>1116 W. Franklin Street</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>1116 W. Franklin Street</u>			
5. SEX <u>F.</u>	6. RACE <u>C.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/29/12</u>	9. AGE (In years last birthday) <u>60</u>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic Worker</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Lynn Adams</u>				14. MOTHER'S MAIDEN NAME <u>Ida Hartfield</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Patricia Grace Alderman</u>	
				ADDRESS <u>2705 Cylburn</u>			
18. <u>412.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <u>PROBABLE CARDIAC ARREST</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE WITH ANGINA PECTORIS</u> <u>5 yrs</u> <u>PREMATURE VENTRICULAR CONTRACTION</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <u>PREMATURE VENTRICULAR CONTRACTION</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <del>the</del> (this hospital) attended the deceased from <u>6/28/72</u> 19 <u>72</u> to <u>9/26/72</u> 19 <u>72</u> , that (I) <del>was</del> last saw the deceased alive on <u>6/28/72</u> 19 <u>72</u> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did not) view the body after death.							
23A. SIGNATURE <u>B. S. Karpers M.D.</u>				23B. DATE SIGNED <u>9/27/72</u>			
23C. PHYSICIAN'S NAME (Type) <u>B. S. KARPERS M.D.</u>				23D. ADDRESS <u>MEDICAL CLINIC</u> <u>UNI OF MARYLAND HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/30/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Westport, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 29 1972</u>		25B. NAME OF REGISTRAR <u>Andrew Johnson</u>		25C. FUNERAL DIRECTOR <u>Charles A. Rice</u>		ADDRESS <u>1300 N. Eutaw PL.</u>	

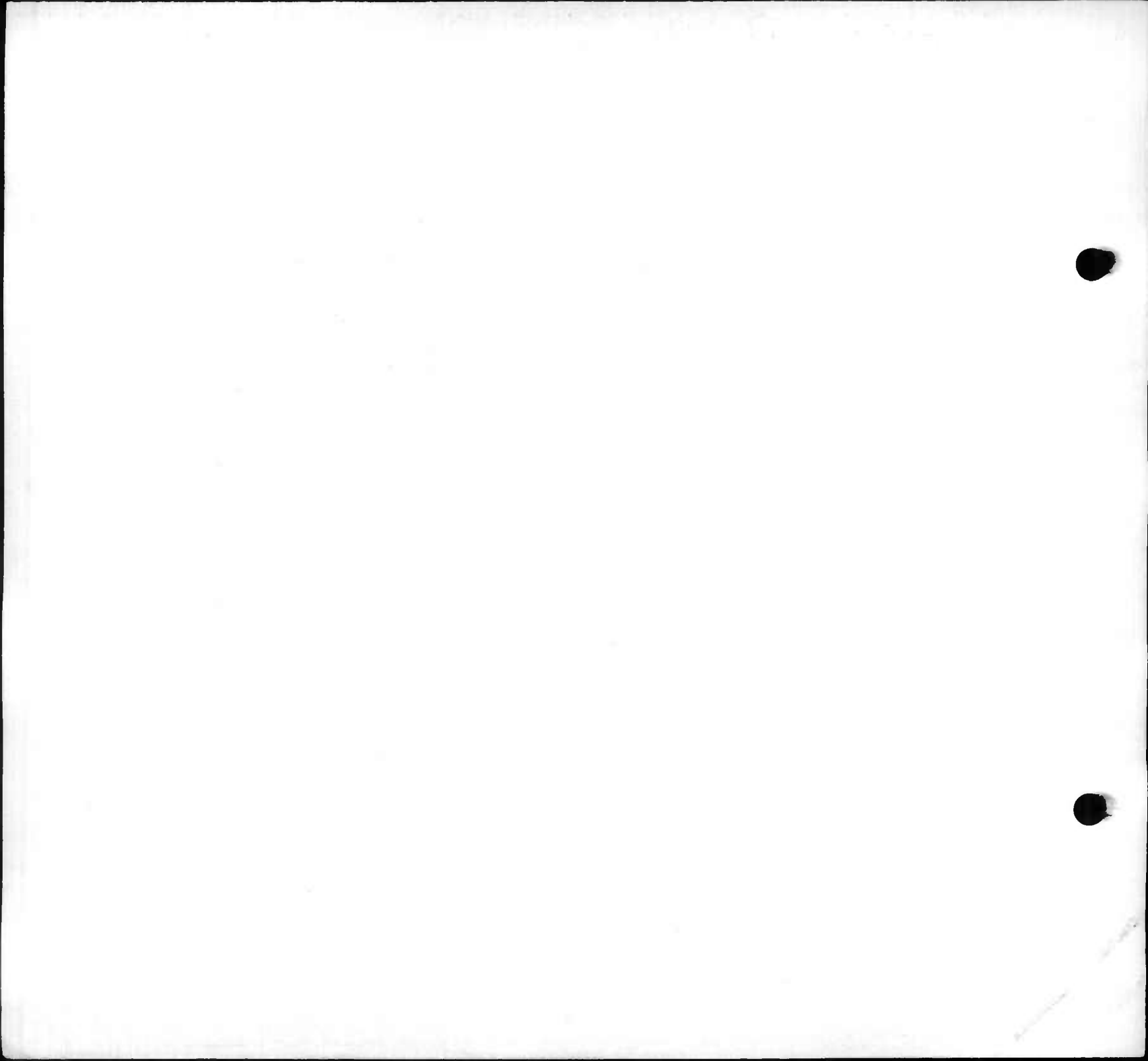




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-300 72 09328		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		72 09328 REG. NO.	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>HEATH MR. OLLIE</u>		2. DATE AND HOUR OF DEATH <u>9/26/72</u> <u>820</u> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution's residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>CITY</u>		CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>BON SECOURS HOSPITAL</u> <u>34</u>		E. STREET AND NUMBER <u>1951 W. FAYETTE ST.</u>			
5. SEX <u>M</u>	6. RACE <u>B</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/2/00</u>	9. AGE (In years last birthday) <u>72</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>?</u>		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>	
13. FATHER'S NAME <u>John Heath</u>		14. MOTHER'S MAIDEN NAME <u>Liza Vincent</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <u>16311</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <u>BRONCHOPNEUMONIC CA</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>29 hours ago</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>9-26-72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notably medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8-31-72</u> 19 to <u>9-26</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>9-26-72</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Felimon A. Soria</u>		23B. DATE SIGNED <u>9-26-72</u>		23C. PHYSICIAN'S NAME (Type) <u>FELIMON A. SORIA</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>9-30-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Brooklyn, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 29 1972</u>		25B. NAME OF REGISTRAR <u>Audrey M. Wilson</u>		25C. FUNERAL DIRECTOR <u>Charles A. Rice</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-430		72 68329		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09329	
BIRTH NO.				STATE OF MARYLAND-DEPT			
1. NAME OF DECEASED (Type or Print) Martha Floyd				2. DATE AND HOUR OF DEATH 9/25/72			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 46 Luthern Hospital				A. STATE Maryland			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 2801 Rayner Ave.			
5. SEX F.	6. RACE C.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/2/91	9. AGE (In years last birthday) 81	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY Unemployd		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Sutherlin				14. MOTHER'S MAIDEN NAME Eliza Payton			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. P19-30-9242A		17. INFORMANT Charles Floyd 425 Round Rd.		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 412.31 4250.9 (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH A-S-H-D. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) Diabetes mellitus			
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6-20-1969 to 9-25-1972, that (I) (we) lost saw the deceased alive on 9-17-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Barbara Allen				23B. DATE SIGNED 9-27-72			
23C. PHYSICIAN'S NAME (Type) DEGREE				23D. ADDRESS DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/29/72		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 29 1972		25B. NAME OF REGISTRAR Sidney Johnston		25C. FUNERAL DIRECTOR Charles A. Rice 1300 Eutaw Place		ADDRESS	

~~N.H. to call back~~

Middlesex Co. Va. 5/15/69

OT

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-522		72 09330		BALTIMORE CITY HEALTH DEPARTMENT		72 09330	
BIRTH NO.				REGISTERED No. 62-00			
M.E. CASE NO.				COUNTY OF MARYLAND AND DISTRICT OF COLUMBIA			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
ALBERT COMEGYS				9:18 PM 9/21/72 9:18 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
Maryland State Penitentiary - Hospital		954 Forest St 2202		2562 Maryland		2562	
D. STREET ADDRESS (If rural, give location)				Baltimore			
2047 Corber Rd.							
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
Male	Negro	Single	11-11-05	66			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
none					Maryland		U.S.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Deceased				Deceased			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no				212-12-715		Mrs. Bernice Bradford 2228 N. Calvert St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CHRONIC OBSTRUCTIVE PULMONARY DISEASE		2 YRS. OR MORE	
ANTECEDENT CAUSES				(A) DUE TO		COR PULMONALE	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO		HYPERTENSION	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 1-27 1966 to 9-21 1972, that (I) (we) last saw the deceased alive on 9/21 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Henry W.D. Holljes M.D.				9/21/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Henry W.D. Holljes				954 Forest Street			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Buried		9-26-72		Mt Auburn Cem		Westport, Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
SEP 29 1972		Sidney H. H. H.		Charles A. Kine		661 B. H. St	

2847 Carver Rd. <sup>7r</sup>

Rice Funeral Home



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09331
72 09331 CERTIFICATE OF DEATH				STATE OF MARYLAND, DDC#
1. NAME OF DECEASED (Type or Print) <b>WILLIAM EDWARD CONOLLEY</b>		2. DATE AND HOUR OF DEATH <b>9. 21. 1972 3. 25 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNION MEMORIAL HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1348</b>		
5. SEX <b>M</b> 6. RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		8. DATE OF BIRTH <b>9. 12. 15</b>		9. AGE (In years last birthday) <b>57</b>
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Wm. E Conolly</b>		14. MOTHER'S MAIDEN NAME <b>ENSOR</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
18. <b>431.0</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>20 h</b> <b>20 h</b> <b>15 years</b>
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) ( <b>this hospital</b> ) attended the deceased from <b>9. 20</b> 19 <b>72</b> to <b>9. 21</b> 19 <b>72</b> , that (I) ( <b>we</b> ) last saw the deceased alive on <b>9. 21</b> 19 <b>72</b> and that in (my) ( <b>our</b> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <b>We</b> ) ( <b>did</b> ) ( <b>did not</b> ) view the body after death.				
23A. SIGNATURE <b>Indirecto Lantz</b>				23B. DATE SIGNED <b>9. 21. 72</b>
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY
<b>Burial</b>		<b>10-1-72</b>		<b>Gettysburg Nat Pk.</b>
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR
<b>SEP 29 1972</b>		<b>Audrey Whitson</b>		<b>PC Warkes E. Hughes</b>
				25D. ADDRESS <b>20223 1532 Hollins st</b>

RECU ST

RECU ST

RECU ST

72 09332

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 09332

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>FREEMAN DEMBY</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1504 W. Baltimore St. (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>9 24 1972 4:55 p.m.</b>	
6. SEX <b>male</b>		7. RACE <b>negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>June-15-1897</b>		10. AGE (In years last birthday) <b>75</b>	
11. BIRTHPLACE (State or foreign country) <b>Bridgetown Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Samuel Demby</b>		14. MOTHER'S MAIDEN NAME <b>Victoria Peters</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>218-09-1178</b>	
17. INFORMANT <b>Maragat Horshaw</b>		18. ADDRESS <b>3934 Edmonson ave</b>	

19. <b>412-4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					

20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>no</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	

23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>9-25-72</b>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			

24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Oct-1-1972</b>		24C. NAME OF CEMETERY or CREMATORY <b>mt Auburn</b>	
24D. LOCATION (City, town, or county) <b>Baltimore Md.</b>		24E. STATE <b>Md.</b>		24F. ZIP CODE <b>21223</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 29 1972</b>		25B. NAME OF REGISTRAR <b>Adolphus...</b>		25C. FUNERAL DIRECTOR <b>Charles E. Hughes</b>	
				ADDRESS <b>1532 Hollins st</b>	

50000 ST

50000 ST

Victory 1975  
2. Annual 1975

USA  
1975

Association of...

...

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 1500

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

72 09333

STATE OF MARYLAND-DHMH

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Rita ROSS

2. DATE AND HOUR OF DEATH

September 27, 1972

3:55 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Midtown Home, Inc.  
808 St. Paul Street  
Baltimore, Maryland 21202

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE  
Maryland

C. CITY OR TOWN

Baltimore,

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

4107 Liberty Hts Avenue

5. SEX

F

6. RACE

B

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

10-2-02

9. AGE (In years last birthday)

69

If Under 1 Yr. Months: Days:

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Augusta, Ga.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Robert Jones

14. MOTHER'S MAIDEN NAME

Archie M. Jones

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

213-36-3611

17. INFORMANT

Eva Nixon

ADDRESS

Same

18.

4/2/51

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

Cardio-Respiratory Failure

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Hypertensive Art. Cvt.

(B)

Parkinson's Disease

DUE TO, OR AS A CONSEQUENCE OF:

(C)

Decubitus Ulcerations

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from June 12 1972 to September 27 1972, that (I) (we) lost saw the deceased alive on 19 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did not) view the body after death.

23A. SIGNATURE

Willard Appleford

DEGREE

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

9-27-72

23C. PHYSICIAN'S NAME (Type)

Willard Appleford

23D. ADDRESS

4107 Liberty Hts Avenue

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

9-30-72

24C. NAME OF CEMETERY OR CREMATORY

Arbutus Memorial Park

24D. LOCATION

Arbutus

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

SEP 29 1972

25B. NAME OF REGISTRAR

Archie M. Jones

25C. FUNERAL DIRECTOR

Elmer J. Wilson

ADDRESS

1000 Brantley Ave





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 09334

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHREG. NO. 72 09334  
STATE OF MARYLAND-DEPT

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Josephine Thomas

2. DATE AND HOUR OF DEATH

9-24-72

340

A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)90 MT. SINAI NURSING HOME  
4613 PARK HEIGHTS AVE  
BALTIMORE, MD 212154. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

1607

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

1126 Poplar Grove ST

5. SEX

Female

6. RACE

Negro

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

8-1-13

9. AGE (In years  
lost birthday)

59

10. Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Montgomery Ala

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Wilson

14. MOTHER'S MAIDEN NAME

OIA

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Frank L. Thomas Senior

ADDRESS

18. 412.21

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

Cerebral Thrombosis

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Hypertension &amp; Thromboplegia

(B) DUE TO, OR AS A CONSEQUENCE OF:

Polychemia Vera

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

2 days

5 years

1 year

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Aug 29 1972 to Sept 24 1972  
that (I) (we) last saw the deceased alive on Sept 24 1972 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Manuel Levin

MD

Attending  
Phys. ☒Med.  
Director ☐Staff  
Phys. ☐

23B. DATE SIGNED

9/27/72

23C. PHYSICIAN'S  
NAME (Type)

MANUEL LEVIN

MD

23D. ADDRESS

6101 Park Heights Ave Balto Md 21215

24A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

9-28-72

24C. NAME OF CEMETERY OR CREMATORY

BALTIMORE CEMETERY

24D. LOCATION

(City, town, or county)

BALTO. MD.

(State)

25A. DATE REC'D BY HEALTH DEPT.

SEP 29 1972

25B. NAME OF REGISTRAR

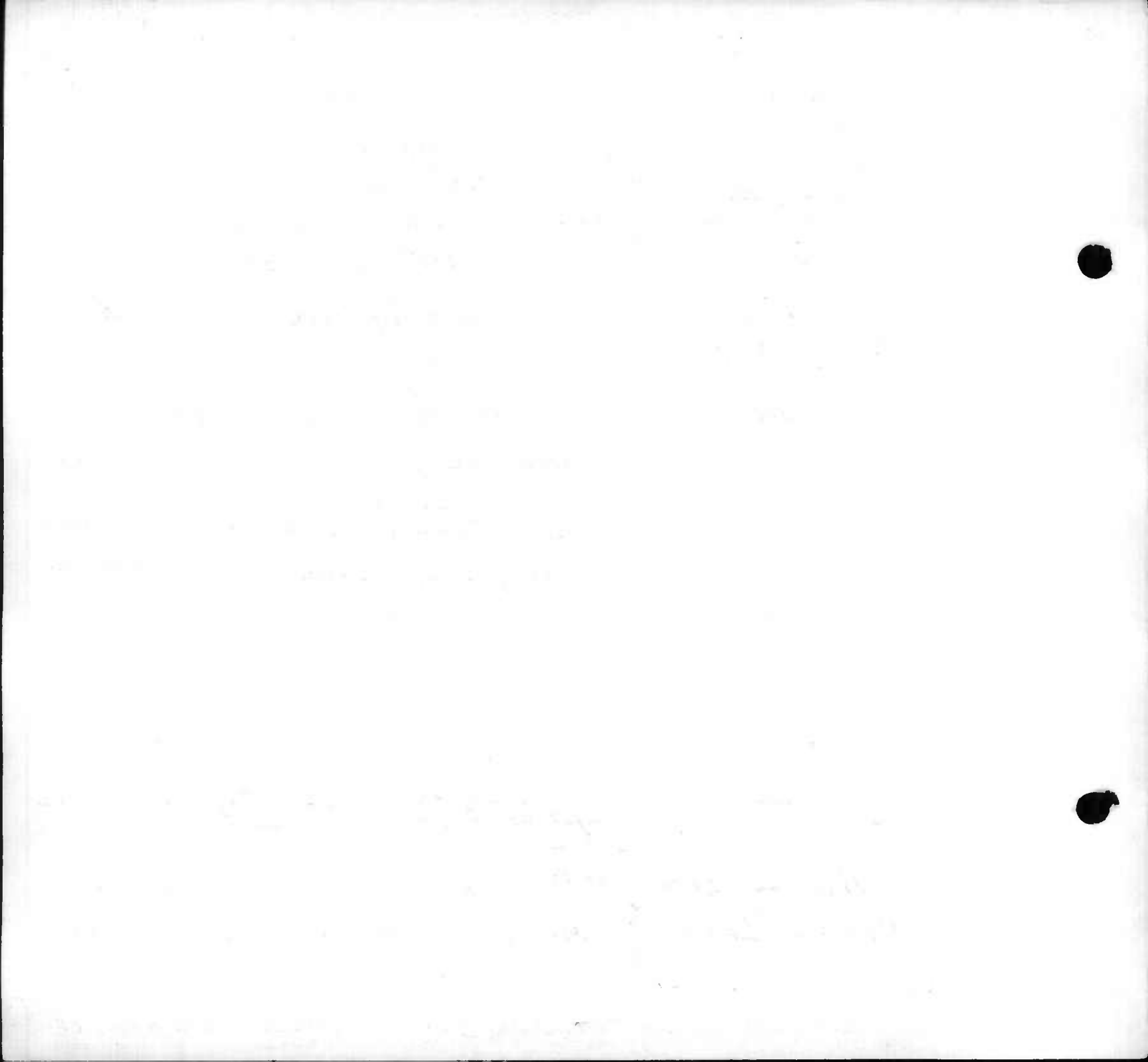
Sidney Thornton

25C. FUNERAL DIRECTOR

O. Wilson 1000 BRANTLEY AVE

ADDRESS





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 09335

BIRTH NO.

STATE OF MARYLAND-DEMD

1. NAME OF DECEASED  
(Type or Print)

SUSAN BAILEY Williams

2. DATE OF DEATH Known ☐ Estimated ☐ Month Day Year Hour M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

1914 Walbrook Ave.

3. DATE PRONOUNCED DEAD Month Day Year Hour M.  
9 25 1972 5:13 a.m.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Md. B. COUNTY 1504

6. SEX

female

7. RACE

negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

March 1-1910

10. AGE (In years last birthday)

62

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

1914 Walbrook Ave.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Robert B. Williams

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Marie Simon

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service)

no

17. SOCIAL SECURITY NO.

18. INFORMANT

ADDRESS

Agnes Toloman Simon

19. 412.2

CAUSE OF DEATH

Hypertensive cardiovascular disease

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL SIGNATURE  
EXAMINER'S NAME (Type)

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒  
ASSISTANT MEDICAL EXAMINER ☐  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9-25-72

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

9-30-72

24C. NAME OF CEMETERY or CREMATORY

Mt Auburn Cem

24D. LOCATION (City, town, or county)

Balto

(State)

MD

25A. DATE REC'D BY HEALTH DEPT.

SEP 29 1972

25B. NAME OF REGISTRAR

Audrey Johnston

25C. FUNERAL DIRECTOR

C. Johnson or Brantley Jr

ADDRESS

1875

1875

1875

1875

1875

1875

1875

1875

1875

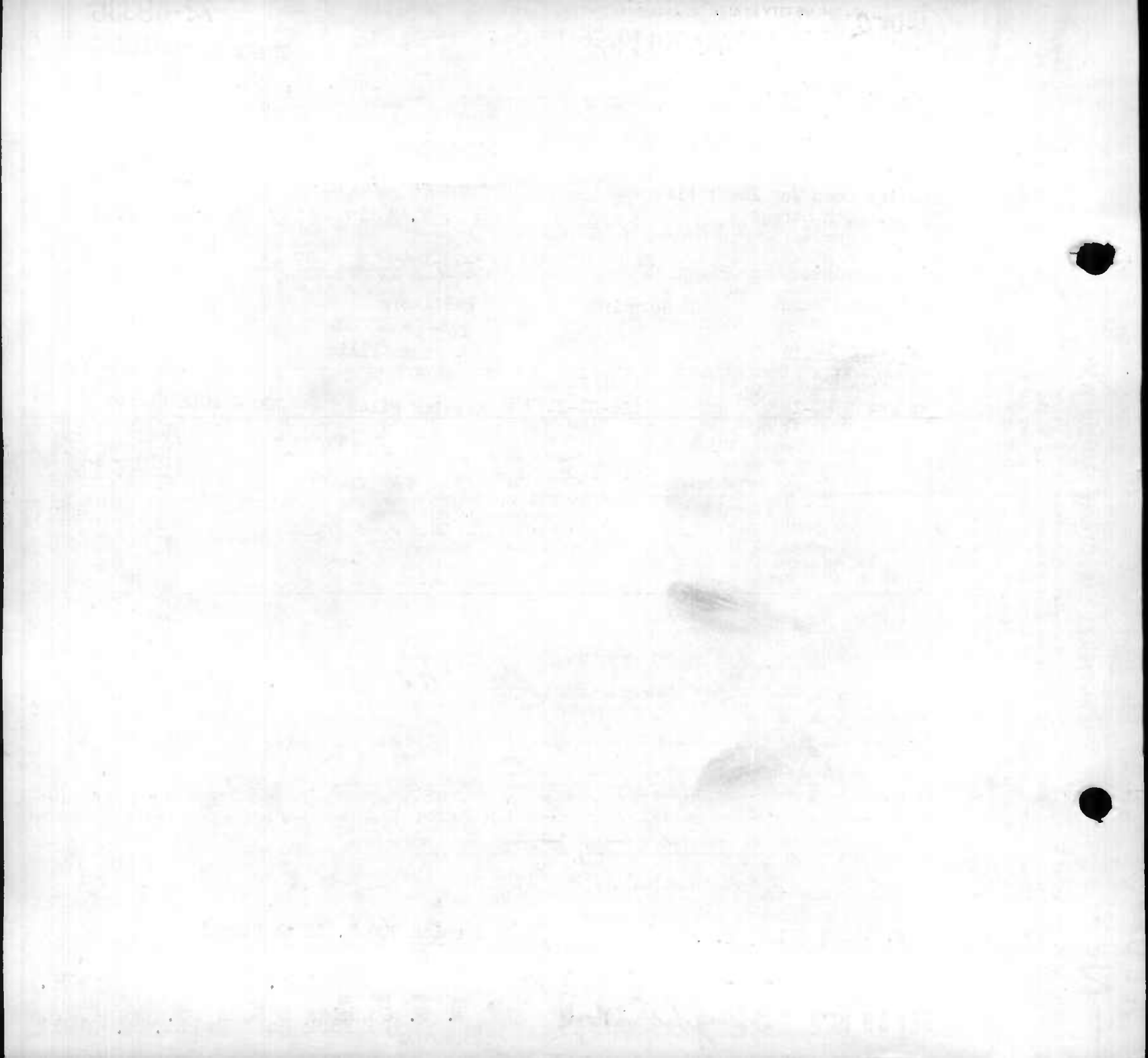
1875

1875

FUNERAL DIRECTOR: IMPORTANT

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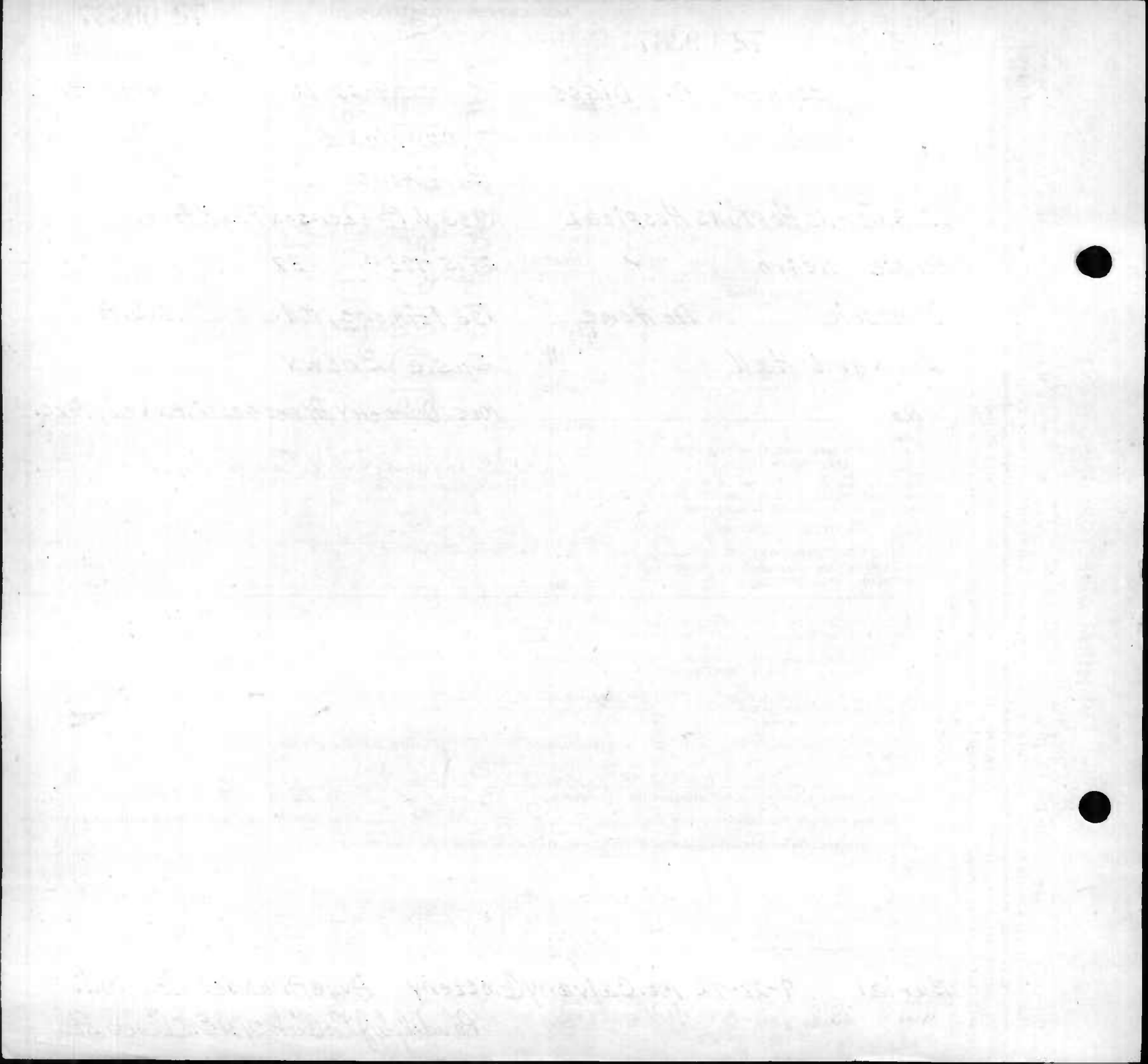
BALTIMORE CITY HEALTH DEPARTMENT				72 09336		72 09336		72 09336	
BIRTH NO.				C-452		72 09336		72 09336	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
Mrs. Helen Larkin Collins				Sept. 28, 1972		11 20 A.M.		STATE OF MARYLAND-DEED	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE		B. COUNTY		C. CITY OR TOWN	
Keswick Home for Incurables 700 W. 40th Street				Maryland		12 01		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX				6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
F.				W.		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		3-28-1895	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Registered Nurse				Nursing		Baltimore		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
William Larkin				Emma Ellis		yes		WW-1	
17. INFORMANT				ADDRESS		18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Keswick Files				700 W 40th Street		Myocardial Infarction		Immediate	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE		DUE TO, OR AS A CONSEQUENCE OF:		10 years	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				Anterior interventricular septal perforator artery disease		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
23. DATE OF OPERATION				24. CONDITION FOR WHICH OPERATION WAS PERFORMED		25. AUTOPSY? (Yes or No)		26. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
27. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				28. PLACE OF INJURY		29. WHERE DID INJURY OCCUR?		30. HOW DID INJURY OCCUR?	
29. TIME OF INJURY (APPROX.)				31. INJURY OCCURRED		32. HOW DID INJURY OCCUR?		33. I certify that (I) (this hospital) attended the deceased from	
34. SIGNATURE				35. DATE SIGNED		36. I certify that (I) (this hospital) attended the deceased from		37. to	
A. Allan Spier M.D.				9/28/72		September 27, 1972		September 28, 1972	
38. PHYSICIAN'S NAME (Type)				39. ADDRESS		40. DATE REC'D BY HEALTH DEPT.		41. NAME OF REGISTRAR	
A. ALLAN SPIER M.D.				Keswick 700 W. 40 th Street		SEP 29 1972		Sidney Whitman	
42. BURIAL CREMATION, REMOVAL (Specify)				43. DATE		44. NAME of CEMETERY or CREMATORY		45. LOCATION	
Burial				9-30-72		Loudon Park		Balto.	
46. DATE REC'D BY HEALTH DEPT.				47. NAME OF REGISTRAR		48. FUNERAL DIRECTOR		ADDRESS	
SEP 29 1972				Sidney Whitman		H. W. Jenkins & Sons Co.		4905 York Road Balto. Md. 21212	



# FUNERAL DIRECTOR: IMPORTANT

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D-200		72 09337		BALTIMORE CITY HEALTH DEPARTMENT		72 09337	
BIRTH NO.		72 09337		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)		Fisher O. Diggs		2. DATE AND HOUR OF DEATH		9-25-72 4:42 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		D.O.A. Johns Hopkins Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		Maryland 703	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
D.O.A. Johns Hopkins Hospital				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
Female		Negro		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		2-15-1934 38	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Domestic		At Home		Baltimore, Md.		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
Bernard Hall		Susie Brown		No		Mrs. Dorothy Adams 2021 Kennedy Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4-10-71		Acute myocardial Infarction Instant					
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:					
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 3-14-1972 to 8-10-1972		that (I) (we) last saw the deceased alive on 8-10-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
Eugene H. Owens M.D.		9-28-72		Eugene H. Owens M.D.		1735 E. Federal St.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		9-28-72		Mt. Calvary Cemetery		Anne Arundel Co., Md.	
25A. NAME REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
Oct 2 1972		Sidney W. ...		Randolph J. ...		2431 E. Oliver St.	





# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. <b>R-000</b>		72 09338		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. <b>72 09338</b>	
1. NAME OF DECEASED (Type or Print) <b>Norman Calvin Rowe</b>				2. DATE AND HOUR OF DEATH <b>Sept. 24, 1972 7:38 P.M.</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>US Public Health Service Hospital 3100 Wyman Parkway</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>SOMERSET</b>					
5. SEX <b>M</b> 6. RACE <b>Colored (negro)</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>1/11/24</b>		9. AGE (In years last birthday) <b>48</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>SEAFOOD</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Marsh Rowe</b>				14. MOTHER'S MAIDEN NAME <b>Lela Jones</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>217-14-8868</b>		17. INFORMANT ADDRESS <b>Records- US PHS Hospital, Balto, Md.</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>160.2 I</b> <b>Complications of carcinoma right maxillary sinus.</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>marked Anemia</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>?</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A): _____									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>Aug. 16</b> 19 <b>72</b> to <b>Sept 24</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>Sept. 24</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Ronald E. Tinsley, M.D.</b>								23B. DATE SIGNED <b>9/25/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Ronald E. Tinsley, Surgeon</b>				23D. ADDRESS <b>US PHS Hospital, Balto, Md.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/30/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Asbury</b>		24D. LOCATION (City, town, or county) (State) <b>Crisfield Md</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 2 1972</b>		25B. NAME OF REGISTRAR <b>Sidney [Signature]</b>		25C. FUNERAL DIRECTOR <b>Anthony E. Ward</b>		25D. ADDRESS <b>Crisfield Md</b>			

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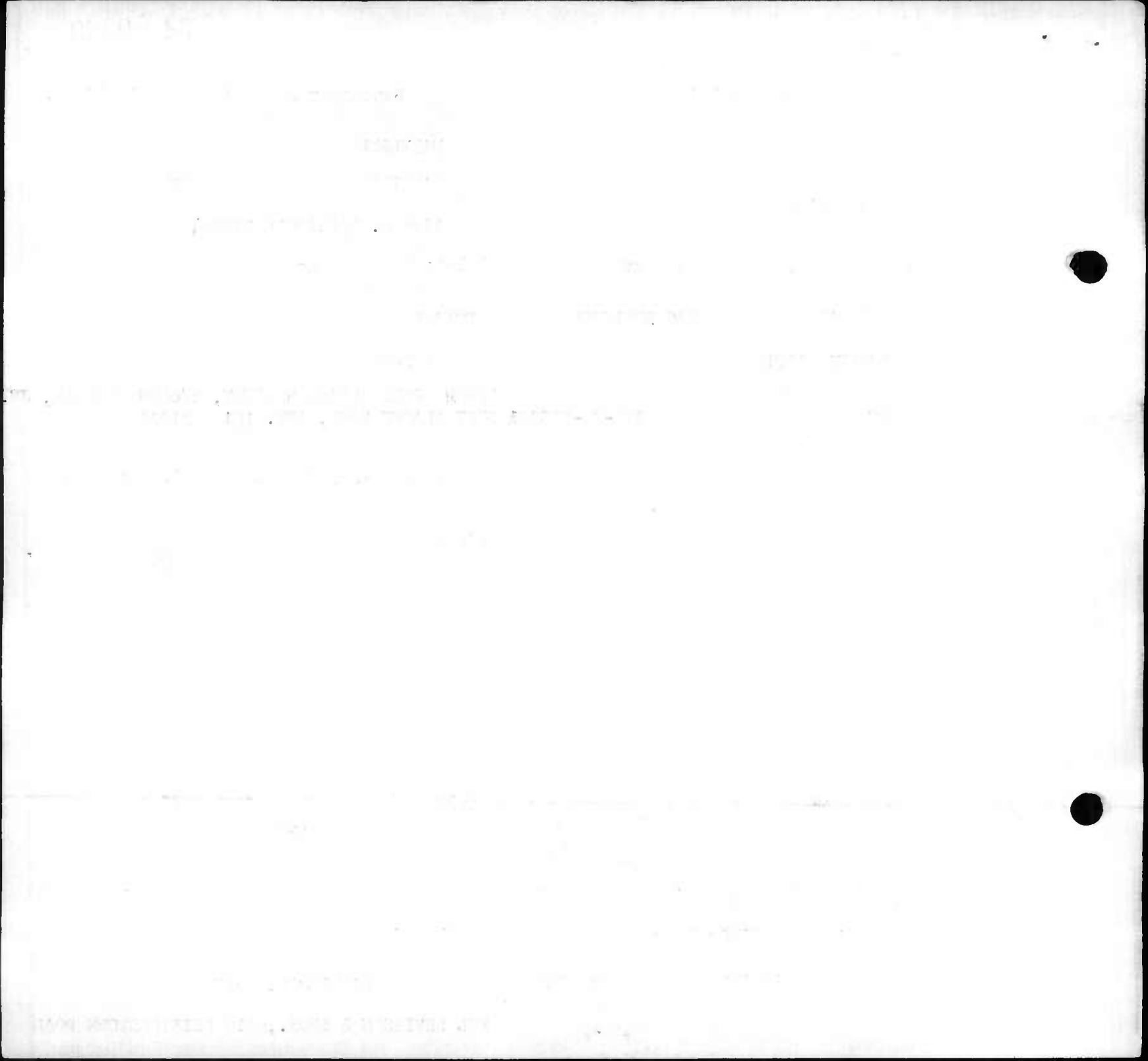
1975

1975

# FUNERAL DIRECTOR: IMPORTANT

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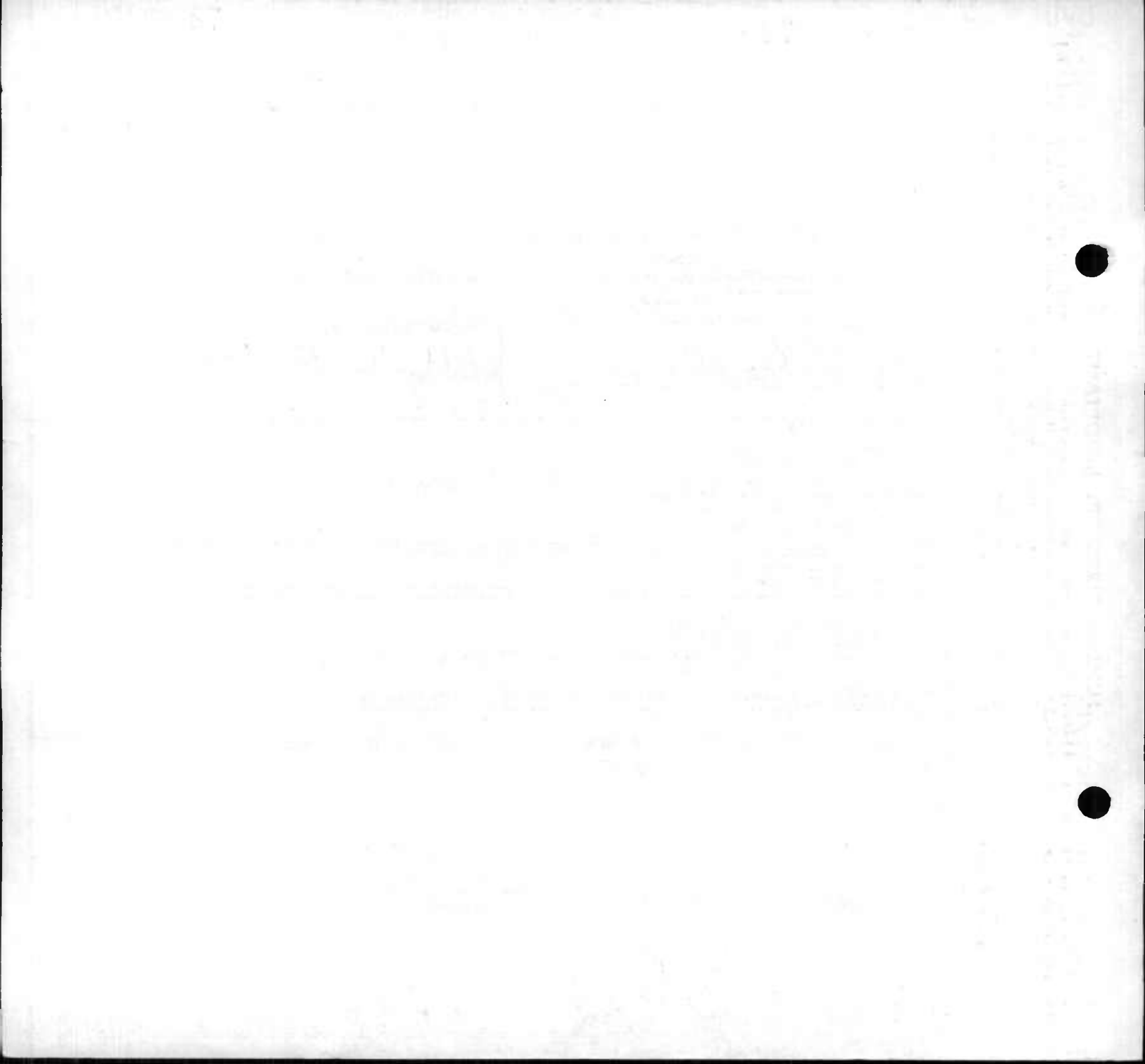
BALTIMORE CITY HEALTH DEPARTMENT		72 09339		REG. NO. 72 09339	
BIRTH NO. 11-520		72 09339		STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print)		JACOB MENSCH		2. DATE AND HOUR OF DEATH September 26, 1972 11:10 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY		MARYLAND 301	
FULL NAME OF HOSPITAL OR INSTITUTION 91 LEVINDALE		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1446 E. BALTIMORE STREET	
5. SEX MALE	6. RACE CAU.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-1-1885	9. AGE (in years last birthday) 87	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EMPLOYEE		10B. KIND OF BUSINESS OR INDUSTRY RAG BUSINESS		11. BIRTHPLACE (State or foreign country) POLAND	
13. FATHER'S NAME SAMUEL MENSCH		14. MOTHER'S MAIDEN NAME UNKNOWN		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service NO		16. SOCIAL SECURITY NO. 220-22-7552J1		17. INFORMANT ADDRESS HEBREW FREE BURIAL SOCIETY, c/o MOSE MORRIS, JR. 3737 CLARKS LANE, APT. 101 #21215	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 470.9 I CAUSE OF DEATH		(A) IMMEDIATE CAUSE Coronary H.D. with acute M.I. DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9-26-1972	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) A. S. C. V. D. DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 2-18-1959 19 to 9-26-1972 19 that (X) (we) last saw the deceased alive on 9-26-1972 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.					
23A. SIGNATURE Jane Younghea Lew M.D.				23B. DATE SIGNED September 26, 1972	
23C. PHYSICIAN'S NAME (Type) Jane Younghea Lew, M.D.				23D. ADDRESS Levindale	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/27/72		24C. NAME of CEMETERY or CREMATORY BALTIMORE HEBREW	
				24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. OCT 2 1972		25B. NAME OF REGISTRAR Andrew W. ...		25C. FUNERAL DIRECTOR'S ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	



# FUNERAL DIRECTOR: IMPORTANT

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P-624		72 09340		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 09340		
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <u>ELLA L. PARSLEY</u>				2. DATE AND HOUR OF DEATH <u>9.27.72</u> <u>3.55 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>U.S.A.</u>				C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>THE UNION MEMORIAL HOSPITAL</u> <u>44</u>				E. STREET AND NUMBER <u>3624 PAINE STREET</u>						
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>06-22-00</u>	9. AGE (In years last birthday) <u>72</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>			11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>John W Russell</u>				14. MOTHER'S MAIDEN NAME <u>Ida M Bossom</u>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>705 09 6488</u>		17. INFORMANT <u>George A Parsley</u>		ADDRESS <u>Same</u>			
18. <u>580X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>ELECTROLYTE IMBALANCE</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>ACUTE RENAL FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 WEEKS</u> <u>1 WEEK</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).										
19A. DATE OF OPERATION <u>0</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>09-14-72</u> 19 <u>72</u> to <u>09-28</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>09-28</u> 19 <u>72</u> and that (n) (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <u>Carlos H. Santillan</u>						23B. DAYE SIGNED <u>09-28-72</u>		23C. PHYSICIAN'S NAME (Type) <u>CARLOS H. SANTILLAN</u>		
23D. ADDRESS <u>THE UNION MEMORIAL HOSPITAL</u>						23E. DEGREE		23F. DEGREE		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>			24B. DATE <u>30 Sept 72</u>			24C. NAME of CEMETERY or CREMATORY <u>Druid Ridge Cemetery</u>			24D. LOCATION (City, town, or county) (State) <u>Pikesville, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 2 1972</u>			25B. NAME OF REGISTRAR <u>George A Parsley</u>			25C. FUNERAL DIRECTOR <u>Burgee Funeral Home</u>			ADDRESS <u>Balto, Md.</u>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>GEORGE D. COMPTON</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> <b>September 28, 1972</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>5206 Gwynn Oak Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>September 28, 1972 11:10 A.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2802</b>	
9. DATE OF BIRTH <b>unknown</b>		10. AGE (In years lost birthday) <b>70</b>	
11. BIRTHPLACE (State or foreign country) <b>W. VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>usa</b>	
13. FATHER'S NAME <b>unknown</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>janitor</b>	
15. MOTHER'S MAIDEN NAME <b>unknown</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>unknown</b>	
17. SOCIAL SECURITY NO. <b>215 05 1410</b>		18. INFORMANT <b>James Mudgett</b>	
19. <b>562.1</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>Yes</b>		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>September 28, 1972</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>10/2/72</b>	
24C. NAME of CEMETERY or CREMATORY <b>Green Way Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Burkley Springs, W. Va.</b>	
25A. DATE REC'D BY HEALTH DEPT <b>OCT 2 1972</b>		25B. NAME OF REGISTRAR <b>Andrew...</b>	
25C. FUNERAL DIRECTOR <b>John T. Stansbury</b>		ADDRESS <b>6411 Windsor Mill Rd.</b>	



12-00 ST

12-00 ST



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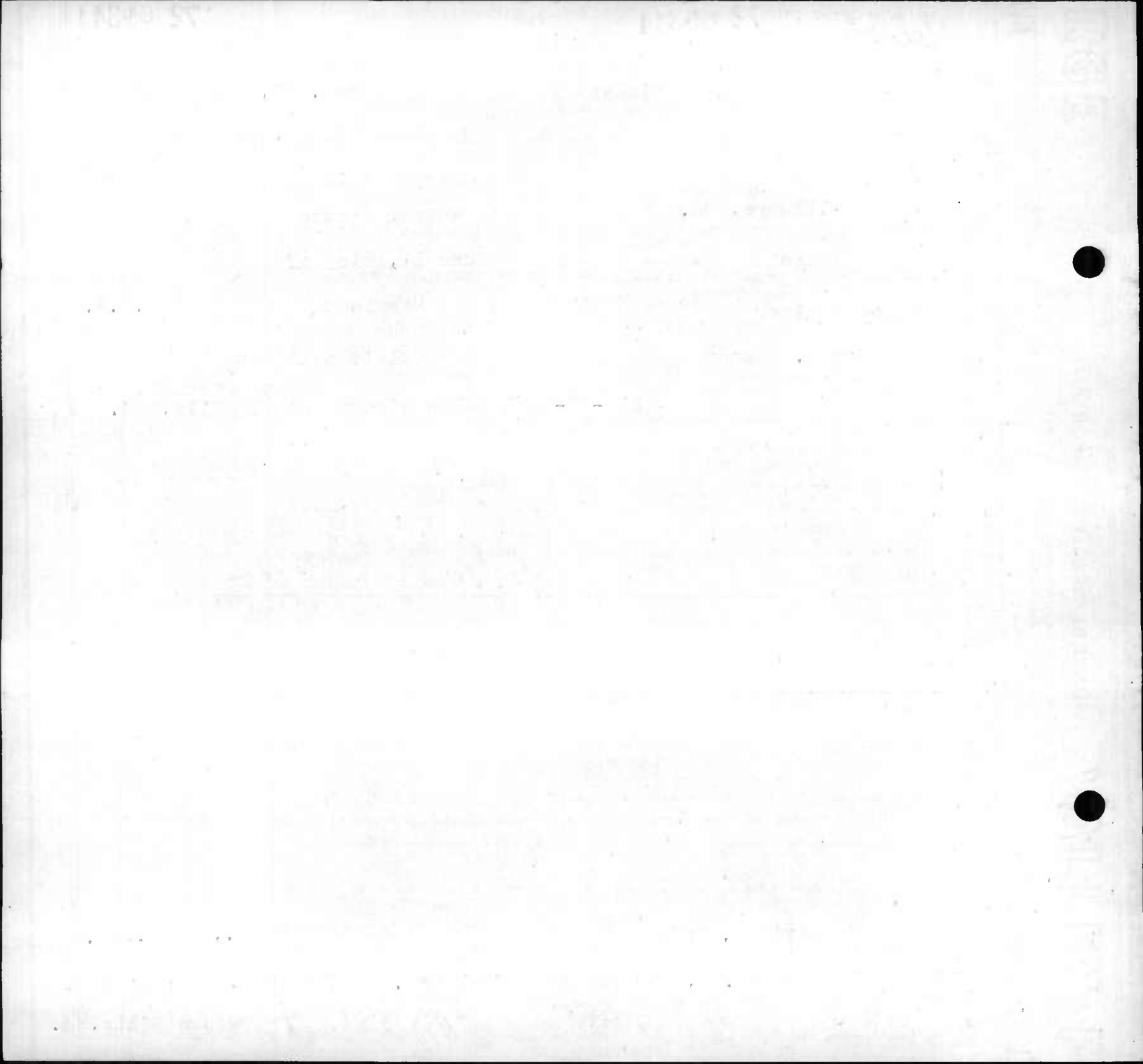
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BALTIMORE CITY HEALTH DEPARTMENT				72 09344	
CERTIFICATE OF DEATH				REG. NO. 72 09344	
BIRTH NO. <i>W-256</i>		1. NAME OF DECEASED (Type or Print) <b>Vernon Allen Wisner</b>			
2. DATE AND HOUR OF DEATH <b>Sept. 27, 1972 1:30 a M.</b>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>42 Sinai Hospital Baltimore, Md.</b>			
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		C. CITY OR TOWN <b>Owings Mills</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>June 15, 1915</b>		9. AGE (In years last birthday) <b>57</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Horse Trainer</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>James B. Wisner</b>	
14. MOTHER'S MAIDEN NAME <b>Goldie Sullivan</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-07-0183</b>	
17. INFORMANT <b>Helen Wisner</b>		ADDRESS <b>Walnut Avenue Owings Mills, Md.</b>		18. CAUSE OF DEATH  DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>I</b> <b>Hemorrhage, Trackel</b> <b>Laryngectomy, Tracheotomy</b> <b>for Carcinoma Larynx</b>	
19. DATE OF OPERATION <b>0</b>		20. AUTOPSY? (Yes or No) <b>No</b>		21. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
22. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>19</b> , that (I) (we) last saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <b>Alvin D. Rudo</b>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>Alvin D. Rudo</b>		23D. ADDRESS <b>6609 Reisterstown Rd., Balto., Md.</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	
24B. DATE <b>Sept. 29, 1972</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Woodlawn, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 2 1972</b>		25B. NAME OF REGISTRAR <b>Alvin D. Rudo</b>		25C. FUNERAL DIRECTOR <b>H. J. Eubank</b>	
25D. ADDRESS <b>Owings Mills, Md.</b>					

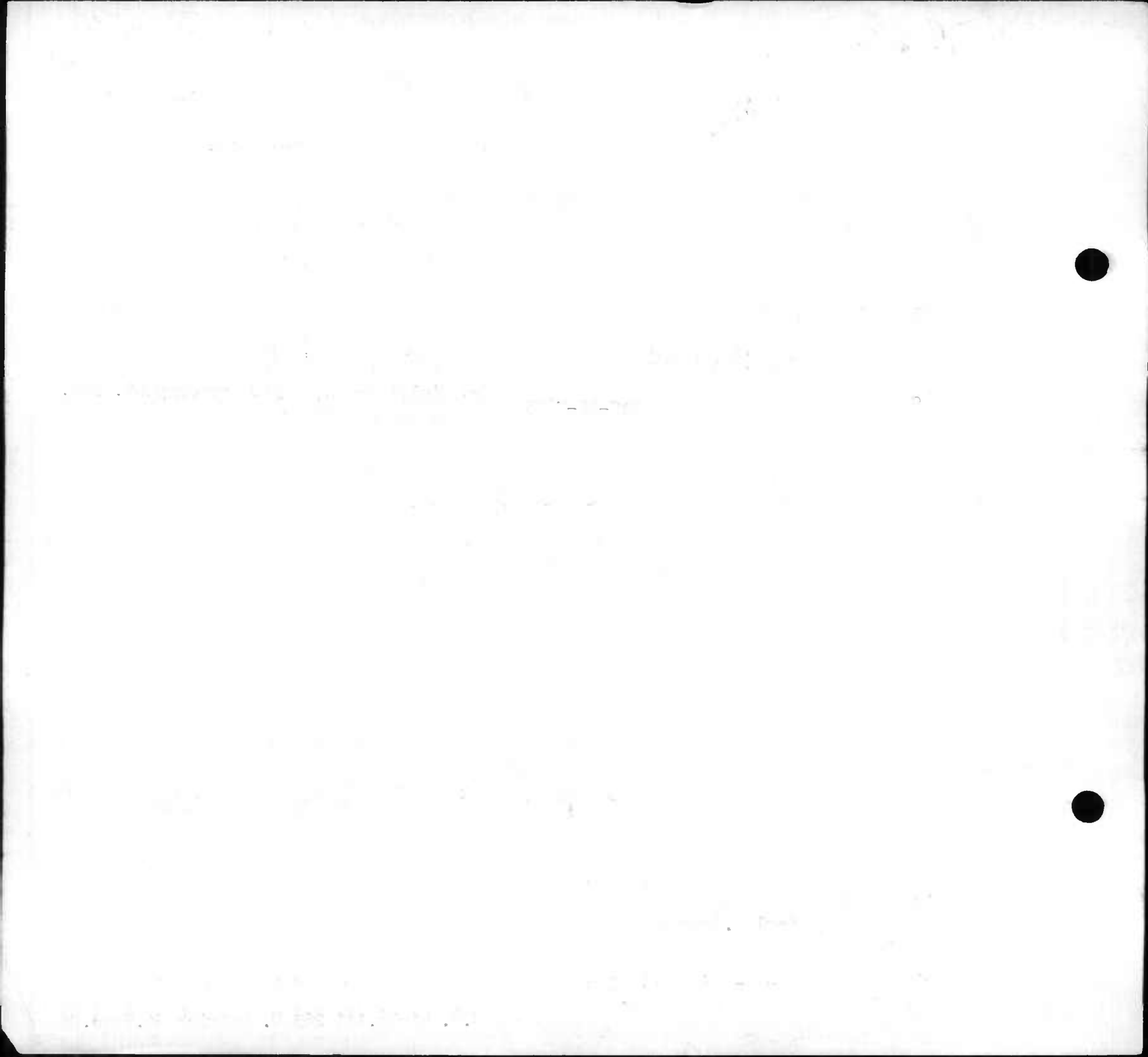




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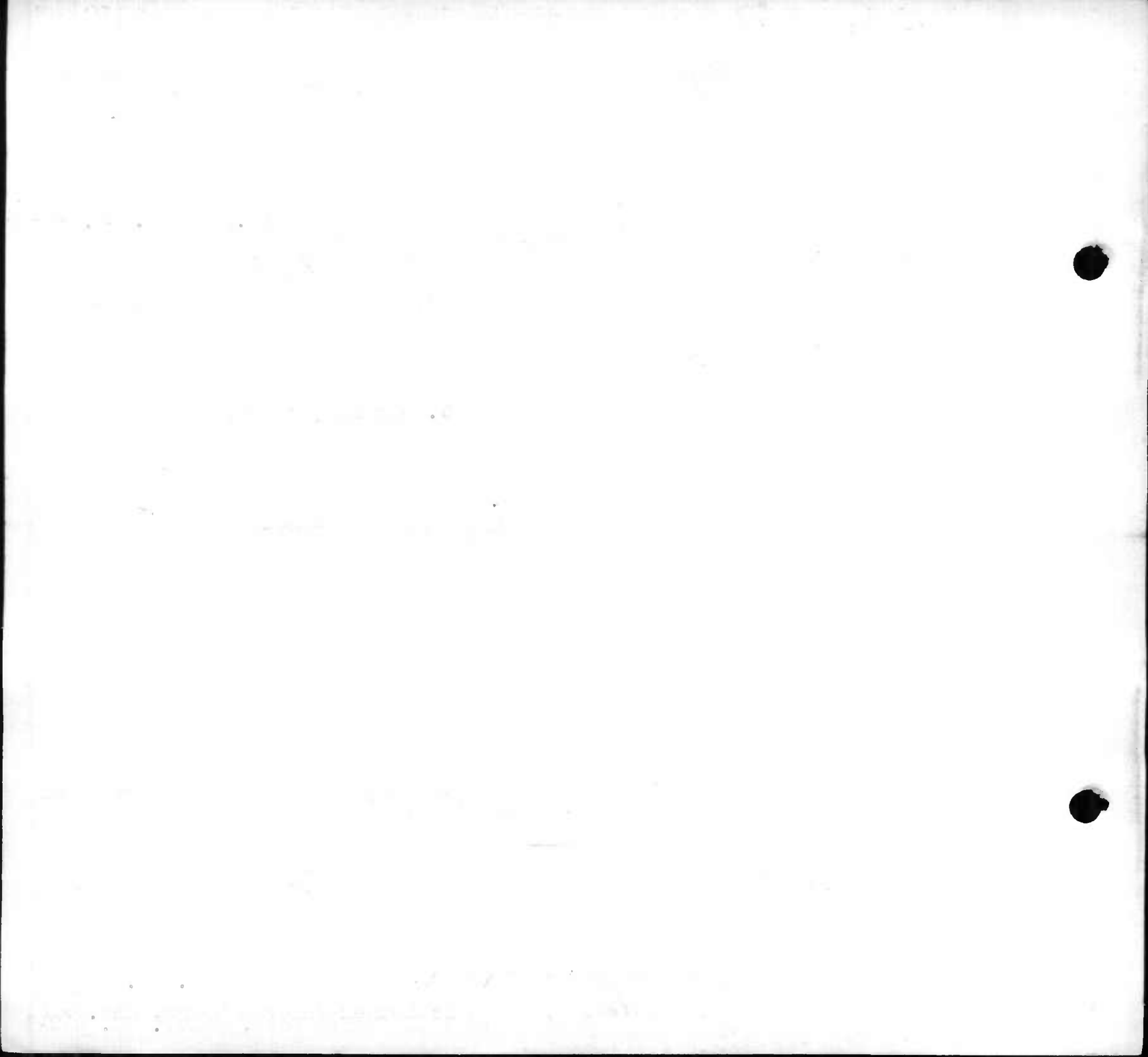
BALTIMORE CITY HEALTH DEPARTMENT				72 09345		REG. NO. 72 09345	
A-512				72 09345		STATE OF MARYLAND-DEPT	
BIRTH NO.				72 09345		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Ambush, Shirley ANN</u>				2. DATE AND HOUR OF DEATH <u>3-30 9/27/72 P</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>U. of Md. Hospital</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Frederick</u> C. CITY OR TOWN <u>Frederick</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>12 CARVER AVE.</u>			
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-4-35</u>		9. AGE (in years last birthday) <u>37</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Claim investigator</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Stewart Ambush</u>				14. MOTHER'S MAIDEN NAME <u>Violet Duckett</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-30-7673</u>		17. INFORMANT <u>Mrs Violet Brown</u> <u>CHART</u>		ADDRESS <u>310 Broadway St, Fred, Md</u>	
18. <u>582 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <u>Anoxic encephalopathy</u> DUE TO, OR AS A CONSEQUENCE OF:  (B) <u>Cordis - pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF:  (C) <u>Chronic renal failure</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>9-22</u> 19 <u>72</u> to <u>9-27</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>9-27</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Carl Jareng</u>				23B. DATE SIGNED <u>9/27/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Carl Jareng</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-30-1972</u>		24C. NAME of CEMETERY or CREMATORY <u>Fairview</u>		24D. LOCATION (City, town, or county) (State) <u>Frederick Frederick Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 2 1972</u>		25B. NAME OF REGISTRAR <u>Shirley Ambush</u>		25C. FUNERAL DIRECTOR <u>C.E. Hicks, 111 263 W. Patrick St, Fred, Md</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-620		72 09346		BALTIMORE CITY HEALTH DEPARTMENT		72 09346	
CERTIFICATE OF DEATH				REG. NO.		STATE OF MARYLAND-DEME	
1. NAME OF DECEASED (Type or Print) <u>Rose Carol Gerwig</u>				2. DATE AND HOUR OF DEATH <u>Sept 28, 1972</u> <u>7 45</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>38 University Hosp.</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALTO</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>114 Lyndale Ave., Balto., Md. 21236</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-30-64</u>	9. AGE (In years last birthday) <u>7 yrs</u>	10. Under 1 Yr. Months	11. Under 24 Hrs. Days	12. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert C. Gerwig</u>				14. MOTHER'S MAIDEN NAME <u>Eleanor Grolaski</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Robt. Gerwig (father) same as above</u>			
18. <u>207.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF:  (B) <u>Sepsis (Gram-)</u> DUE TO, OR AS A CONSEQUENCE OF:  (C) <u>Leukemia</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Sept 27 19 72</u> to <u>Sept 28 19 72</u> that (I) (we) last saw the deceased alive on <u>Sept 28 19 72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Roberta Lucas, MD</u>				23B. DATE SIGNED <u>9/28/72</u>			
23C. PHYSICIAN'S NAME (Type) <u>R. Lucas M.D.</u>				23D. ADDRESS <u>Univ. Hosp.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/30/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Gardens of Faith Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
25A. NAME OF REGISTRAR <u>John J. ...</u>				25B. FUNERAL DIRECTOR ADDRESS <u>Schlimmek Funeral Homes, Inc. 3331 Brehms Lane, Balto., Md. 21213</u>			



STATE OF MARYLAND - DEMO BALTIMORE CITY HEALTH DEPARTMENT									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
BIRTH NO. <u>X-620 72 09347</u>					REG. NO. <u>72 09347</u>				
1. NAME OF DECEASED (Type or Print) <u>M. Vlasta Krejci</u>					2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month <u>9</u> Day <u>27</u> Year <u>72</u> Hour <u>11:10P</u> M.				
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>31 Baltimore City Hospitals</u>					3. DATE PRONOUNCED DEAD Month <u>9</u> Day <u>27</u> Year <u>72</u> Hour <u>11:10 P</u> M.				
6. SEX <u>Female</u>					7. RACE <u>White</u>				
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>BALTO</u>				
9. DATE OF BIRTH <u>7/9/20</u>					10. AGE (In years lost birthday) <u>52</u>				
11. BIRTHPLACE (State or foreign country) <u>Md.</u>					12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>Joseph Pospisil</u>					14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Radio Assembler</u>				
15. MOTHER'S MAIDEN NAME <u>Bendix Corp.</u>					16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>				
17. SOCIAL SECURITY NO. <u>214-14-8747</u>					18. INFORMANT <u>Joseph Krejci (husband) same as above</u>				
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					20. DATE OF OPERATION <u>2</u>				
21. AUTOPSY? (Yes or No) <u>Yes</u>					22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Arteriosclerotic cardiovascular disease</u>				
23. TIME OF INJURY (APPROX.) Month <u>9</u> Day <u>27</u> Year <u>72</u> Hour <u>11:10P</u> M.					24. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>7510 Berkshire Road, Balto. 21224</u>				
25. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					26. HOW DID INJURY OCCUR? <u>Arteriosclerotic cardiovascular disease</u>				
27. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					28. DATE <u>10/2/72</u>				
29. ACTUAL SIGNATURE OF EXAMINER'S NAME (Type) <u>Marvin S. Platt, M.D.</u>					30. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>				
31. DATE REC'D BY HEALTH DEPT. <u>OCT 2 1972</u>					32. NAME OF REGISTRAR <u>Aditya</u>				
33. DATE OF BURIAL <u>10/2/72</u>					34. NAME OF CEMETERY or CREMATORY <u>Oak Lawn Cemetery</u>				
35. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>					36. FUNERAL DIRECTOR <u>Schimunek Funeral Homes, Inc.</u>				
37. ADDRESS <u>3331 Brehms Lane, Balto. Md.</u>					38. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>21213</u>				

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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 09348</b>
M-500 <b>72 09348</b>		<b>CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
MOONEY, GEORGE JOSEPH		SEPTEMBER 28, 1972 1:30 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
ST. AGNES HOSPITAL		MARYLAND BALTIMORE 21227		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN		D. INSIDE CITY LIMITS?
ST. AGNES HOSPITAL		BALTIMORE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
E. STREET AND NUMBER		5. SEX		
2853 TENNESSEE AVE.		MALE		
6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH
CAUCASIAN		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		06 13 94
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)
TAILOR		CLOTHING		78
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
MARYLAND		U.S.A.		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
MARTIN MOONEY		Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT
YES W.W.#1		215014107		RECORDS OF ST. AGNES HOSPITAL
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		
185 X I		METASTATIC PROSTATIC CARCINOMA		
(This does not mean the mode of dying, e.g., heart failure, atherosclerosis, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:		
II		ASCVD, RENAL FAILURE, EMBOLISM OF SUPERFICIAL FEMORAL ARTERY		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
SEPT 26, 1972		EMBOLUS OF FEMORAL ARTERY		NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (X) (this hospital) attended the deceased from SEPTEMBER 26 1972 to SEPTEMBER 28 1972, that (X) (we) last saw the deceased alive on SEPTEMBER 28 1972 and that in (X) (my) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.				
23A. SIGNATURE				23B. DATE SIGNED
[Signature] CHAIRMAN				09 28 72
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
SUNTHORN MAIRISIE MD		AVES. BALTO. MD 21229 ST. AGNES HOSPITAL-CATON & WILKENS		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY
Burial		10/2/72		Holy Cross Cemetery
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR
OCT 2 1972		[Signature]		Glen Burnie, Maryland
25D. ADDRESS		25E. ADDRESS		
237 Patapsco Ave. 21225		237 Patapsco Ave. 21225		



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MOORE, GRACE WILSON  
SEPTEMBER 22, 1904

HARVARD UNIVERSITY

BALTIMORE

ST. AGNES HOSPITAL

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ST. AGNES HOSPITAL

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SEPTEMBER 22, 1904

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ST. AGNES HOSPITAL, BALTIMORE, MD.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Howard Dawson		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 9 27 72 2:30 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital		3. DATE PRONOUNCED DEAD Month Day Year 9 27 72 2:30 P. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission) A. STATE Maryland B. COUNTY 1902	
9. DATE OF BIRTH April 9, 1918		10. AGE (In years last birthday) 54	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Clarence Dawson		14. MOTHER'S MAIDEN NAME Iva ----	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		16. KIND OF BUSINESS OR INDUSTRY Painting contractors	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		18. SOCIAL SECURITY NO. 220-10-7310	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		18. INFORMANT Mrs. Emma Jean Dawson-Martinsburg, W. Va.	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1327 Booth Street 1902		22D. TIME OF INJURY (Approx.) 26 72 8:50P.m.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? shot self in head	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Marvin S. Platt</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Marvin S. Platt, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 9-28-72 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 9-30-72	
24C. NAME OF CEMETERY or CREMATORY Rosedale Cemetery		24D. LOCATION (City, town, or county) (State) Martinsburg, West Virginia	
25A. DATE REC'D BY HEALTH DEPT. OCT 2 1972		25B. NAME OF REGISTRAR Howard K. Brown	
25C. FUNERAL DIRECTOR Brown Funeral Home, Inc. Martinsburg, W. Va.		ADDRESS	

THE UNITED STATES OF AMERICA

DEPARTMENT OF THE ARMY

OFFICE OF THE CHIEF OF STAFF

WASHINGTON, D. C.

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 09350 BALTIMORE CITY HEALTH DEPARTMENT REG. NO. 72 09350 STATE OF MARYLAND - <del>DEME</del>	
BIRTH NO. <u>S-354</u> 1. NAME OF DECEASED (Type or Print) <b>Winifred Genevieve Stanley</b> 2. DATE AND HOUR OF DEATH <b>Sept. 27, 1972</b> <b>2:30. 4</b> <small>P.M.</small>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>CERTIFICATE AMENDED</b> <b>US Public Health Service Hospital</b> <b>3100 Wyman Parkway</b> 10-10-72	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>W. Va.</b> B. COUNTY <b>Shepherdstown</b> C. CITY OR TOWN <b>Shepherdstown</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>206 W. High Street</b>	
5. SEX <b>F</b> 6. RACE <b>Caucasian</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>12/27/29</b> 9. AGE (In years last birthday) <b>49</b> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b> 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) <b>W. Va.</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas Jones</b> 14. MOTHER'S MAIDEN NAME <b>Mary G. <del>Rightstein</del> Rightstine</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b> 16. SOCIAL SECURITY NO. <b>233-70-2187</b> 17. INFORMANT <b>Records- US PHS Hospital, Balto, Md.</b> ADDRESS	
18. <b>205.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).	
CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>RESPIRATORY ARREST</b> <b>MINUTES</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>BRONCHOPNEUMONIA</b> <b>2 DAYS</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>ACUTE MYELOGENOUS LEUKEMIA</b> <b>1 year</b>	
19A. DATE OF OPERATION <b>Sept. 27</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <b>yes</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> Work At Work 21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Sept. 8</b> <b>1972</b> <b>Sept. 27</b> <b>1972</b> that (I) (we) last saw the deceased alive on <b>Sept. 27</b> <b>1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE <b>Robert H. Kirschner</b> 23B. DATE SIGNED <b>9/27/72</b> 23C. PHYSICIAN'S NAME (Type) <b>Robert H. Kirschner, Surg (R)</b> 23D. ADDRESS <b>US PHS Hospital, Balto, Md. 21211</b> DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b> 24B. DATE <b>9-29-72</b> 24C. NAME OF CEMETERY OR CREMATORY <b>Elmwood Cemetery</b> 24D. LOCATION (City, town, or county) (State) <b>Shepherdstown, Jefferson W. Va.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 2 1972</b> 25B. NAME OF REGISTRAR <b>Brown Funeral Home, Inc.</b> 25C. FUNERAL DIRECTOR ADDRESS <b>Martinsburg, W. Va.</b>	

10-10-1972 - Letter from Funeral Director, Charles M. Brown of Brown Funeral Home, Inc.  
327 W. King Street, Martinsburg, West Virginia - 25401 requesting corrections.

HRS

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 9351 STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print) <b>ANNETTE DELILAH AWKWARD</b>				2. DATE AND HOUR OF DEATH <b>SEP 23, 1972</b>		EDT <b>4:25 P</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>MONT.</b>		<b>6500</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>US Public Health Service Hospital Wyman Park Drive and 31st Street</b>				C. CITY OR TOWN <b>Sandy Spring</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>19100 Chandlee Mill Road</b>				5. SEX <b>F</b>		6. RACE <b>N</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>2/23/15</b>		9. AGE (In years last birthday) <b>57</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hswf</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Rhode Island</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Unk</b>			
14. MOTHER'S MAIDEN NAME <b>Edith Miller</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>Unk</b>				17. INFORMANT <b>Records-USPHS Hospital, Balto. Md.</b>			
18. <b>202.11</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Septicemia</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Mycois Fungoides</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 days</b> <b>10 Years</b>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>August 19</b> 19 <b>72</b> to <b>September 23</b> 19 <b>72</b> , that (I) <del>(was)</del> last saw the deceased alive on <b>September 23</b> 19 <b>72</b> and that in (my) <del>(was)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(was)</del> (did) <del>(did not)</del> view the body after death.							
23A. SIGNATURE <b>J. Leonard Lichtenfeld M.D.</b>						23B. DATE SIGNED <b>9/23/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>J. Leonard Lichtenfeld M.D.</b>						23D. ADDRESS <b>US PHS Hospital, Balto. Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-27-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Ash Memorial Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Sandy Spring, Montg. Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 2 1972</b>		25B. NAME OF REGISTRAR <b>Tracy Johnson</b>		25C. FUNERAL DIRECTOR <b>George R. Snowden</b>		ADDRESS <b>Rockville Md.</b>	







# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 09352		BALTIMORE CITY HEALTH DEPARTMENT		72 09352	
R-520		CERTIFICATE OF DEATH		REG. NO. STATE OF MARYLAND-DEATH	
1. NAME OF DECEASED (Type or Print) <b>RANOCCHIA, SAMUEL</b>		2. DATE AND HOUR OF DEATH <b>9/25/72 3:30 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>Church Home &amp; Hospital 100 North Broadway St.</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTIMORE</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Church Home &amp; Hospital 100 North Broadway St.</b>		C. CITY OR TOWN <b>Dundalk</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
		E. STREET AND NUMBER <b>1719 Rita Road 1719 RITA ROAD.</b>			
5. SEX <b>M</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-14-16</b>	9. AGE (In years last birthday) <b>56</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MACHINE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Martin Marietta</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>RALPH RANOCCHIA</b>		14. MOTHER'S MAIDEN NAME <b>GRACE MAGGIO</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war and dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217096896</b>		17. INFORMANT <b>Wife:</b> ADDRESS <b>1719 Rita Road Dundalk, Md. 21222</b>	
18. <b>410.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) <b>CARDIOGENIC SHOCK. ACUTE M. Infarction.</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>PULMONA EDEMA. ARTERIOSCLEROTIC HEART.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>immediately. days ago.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>DISEASE.</b>		(C) _____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>9/10/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/10/72</b> 19 to <b>9/25/72</b> 19 that (I) (we) last saw the deceased alive on <b>9/25/72</b> 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>W. J. Maggioni</b>				23B. DATE SIGNED <b>9/25/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>WALKER, INPATIENTELLI</b>		23D. ADDRESS <b>Church Home &amp; Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-29-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 2 1972</b>		25B. NAME OF REGISTRAR <b>John J. Duda</b>		25C. FUNERAL DIRECTOR <b>John J. Duda</b> ADDRESS <b>7922 Wise Ave. Dundalk, Md. 21222</b>	

SECRET

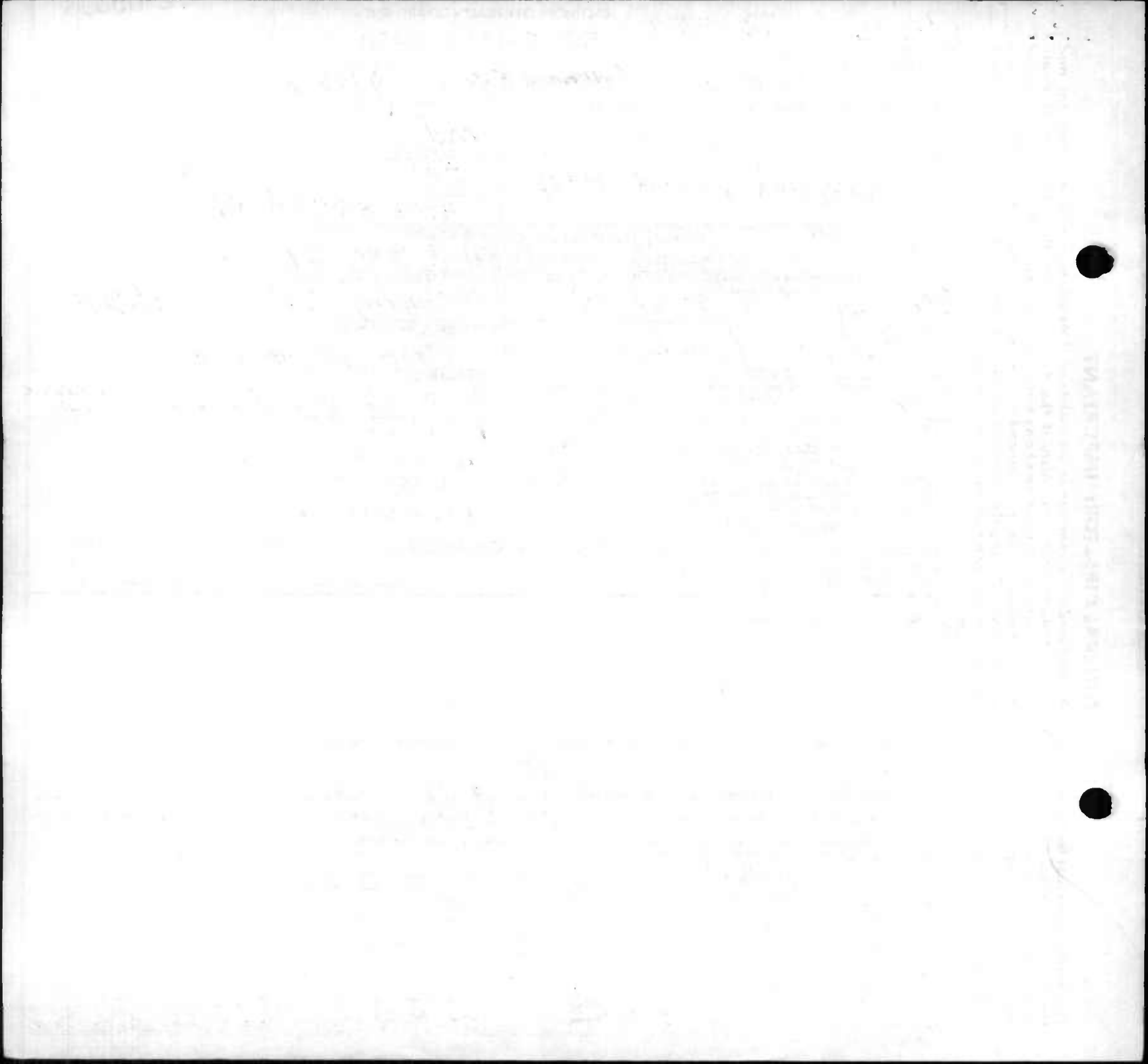
SECRET

DA

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

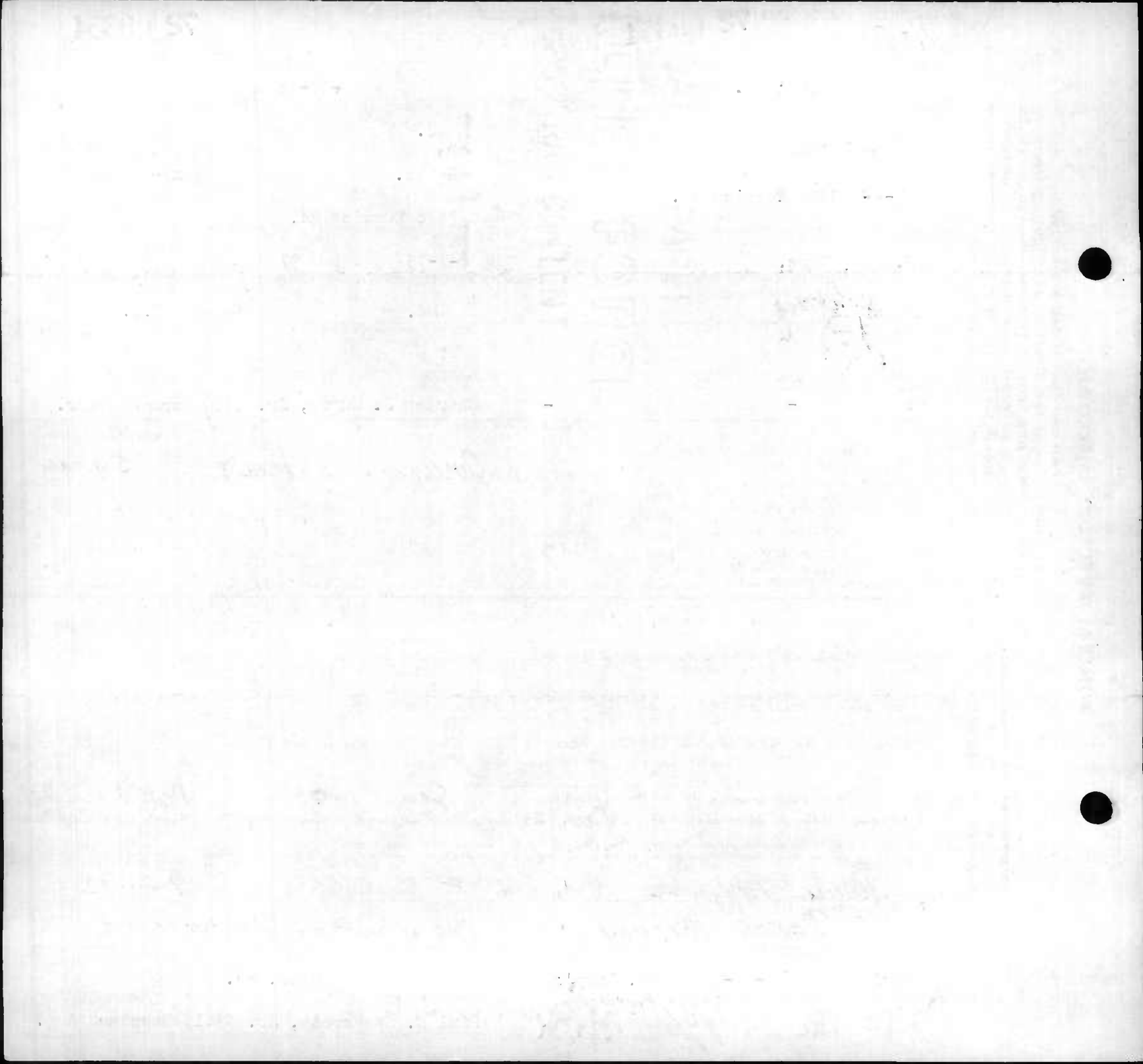
C-616		72 09353		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
BIRTH NO.		CERTIFICATE OF DEATH				STATE OF MARYLAND, DEPT.	
1. NAME OF DECEASED (Type or Print)		Crawford, Catherine Eleanor		2. DATE AND HOUR OF DEATH		9/26/72 5:50 a.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
48 Maryland General Hosp.				Md.		2733	
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				4708 Hanford Rd.			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
F	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Oct 18, 1930		42 yr	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Secretary clerk		St. of Md.		Baltimore, Md.		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Carroll Crawford				Cora Brandenburg			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		None		216286757		Mr. Lysle Brandenburg	
						Glen Burnie Md.	
18. 238.11		CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		Aspiration					
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE		Possible (R) sided brain			
ANTECEDENT CAUSES		DUE TO, OR AS A CONSEQUENCE OF:					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Rt. parietal Br. tumor					
		(C) type ?					
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 9/21/72 to 9/26/72 that (I) (we) last saw the deceased alive on 9/26/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Bharat Desai				9/26/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Bharat Desai				Maryland General Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		9-29-72		Marlowe Park		Elkridge Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
OCT 2 1972		[Signature]		Singleton		Glen Burnie Md.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09354		72 09354	
M-500				72 09354		72 09354	
BIRTH NO.				REG. NO.		STATE OF MARYLAND DEPT.	
1. NAME OF DECEASED (Type or Print) <b>Annie G. Mumaw</b>				2. DATE AND HOUR OF DEATH <b>9-27-72</b> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>00342 3436 Keswick Rd.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1306</b>			
5. SEX <b>F.</b>		6. RACE <b>Cauc.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-2-75</b>	
9. AGE (In years last birthday) <b>97</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>?</b>				14. MOTHER'S MAIDEN NAME <b>?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Charles J. Mumaw, Jr. 2310 Harmony Terr.</b>	
18. <b>174X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Carcinoma of breast</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>9-29-72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>Jan 1965</b> to <b>Sept. 27 1972</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>Sept. 25 1972</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) (did not) view the body after death.							
23A. SIGNATURE <b>Reuben Hoffman</b>				23B. DATE SIGNED <b>9-29-72</b>			
23C. PHYSICIAN'S NAME (Type) <b>REUBEN HOFFMAN, M.D.</b>				23D. ADDRESS <b>846 W. 36th St., Baltimore, Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-30-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>St. Mary's</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 2 1972</b>				25B. FUNERAL DIRECTOR <b>Paul E. Chenoweth, Jr. 3615 Chestnut Ave.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <b>72 09355</b> STATE OF <b>MARYLAND</b>
1. NAME OF DECEASED (Type or Print) <b>Kelly, Dorothy M.</b>		2. DATE AND HOUR OF DEATH <b>September 27, 1972   2:45 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>102</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>THE JOHNS HOPKINS HOSPITAL</b> <b>BALTIMORE, MD 21205</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>FEMALE</b>		6. RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>04-22-10</b>		9. AGE (In years last birthday) <b>62</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>ANDREW KITCHENRIDER</b>		14. MOTHER'S MAIDEN NAME <b>THERESA STANGER</b>		
15. Was Deceased Ever in U. S. Armed Forces (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>Joseph P. Kelly 205 S. Ellwood Avenue</b>
18. <b>153.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(A) IMMEDIATE CAUSE <b>CARDIORESPIRATORY ARREST</b>		<b>0</b>		
(B) <b>Metastatic Carcinoma of bowel</b>		<b>9+ Months</b>		
(C) _____		_____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Hypoglycemia</b>		_____		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>September 15 1972</b> to <b>September 27 1972</b> that (I) (we) last saw the deceased alive on <b>September 27 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <b>did</b> (did not) view the body after death.				
23A. SIGNATURE <b>Douglas J. Deutsch M.D.</b>				23B. DATE SIGNED <b>September 27, 1972</b>
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/30/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Most Holy Redeemer Cemetery Baltimore, Maryland</b>
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 2 1972</b>		
25B. NAME OF REGISTRAR <b>Sidney H. ...</b>		25C. FUNERAL DIRECTOR <b>John A. Moran, Inc.</b>		
25D. ADDRESS <b>3000 E. Baltimore St.</b>		25E. ADDRESS <b>Baltimore, Md. 21224</b>		



COMMUNICATIONS AREA

RECEIVED 10/10/50

10/10/50

RECEIVED 10/10/50

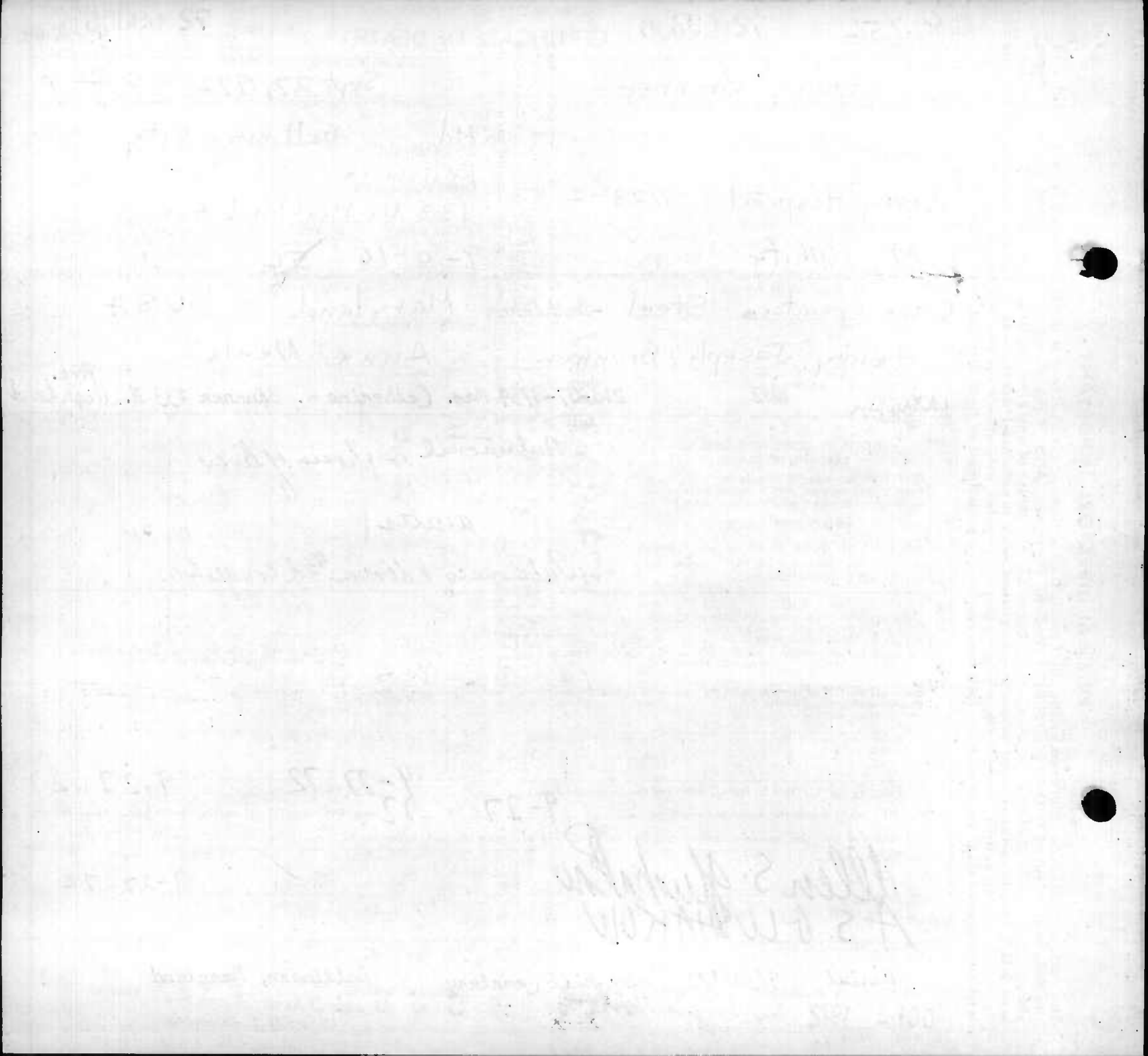
10/10/50

10/10/50

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>B-656 72 09356</b></p> <p><b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. <b>72 09356</b></p> <p><b>STATE OF MARYLAND - DEME</b></p>	
<p><b>BIRTH NO.</b></p> <p>1. NAME OF DECEASED (Type or Print) <b>Henry F. Brunner</b></p>		<p>2. DATE AND HOUR OF DEATH</p> <p><b>Sept 27, 1972 9:00 p.m.</b></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p><b>Mercy Hospital 1123-2</b></p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</p> <p>A. STATE <b>Md</b> B. COUNTY <b>Baltimore City</b></p> <p>C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <b>133 N. Highland Ave.</b></p>	
<p>5. SEX <b>M</b></p>	<p>6. RACE <b>White</b></p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></p> <p>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <b>9-10-16</b></p>
<p>9. AGE (In years last birthday) <b>56</b></p>		<p>If Under 1 Yr. Months: Days: Hours: Min.</p>	<p>If Under 24 Hrs. Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p><b>Crane Operator</b></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p> <p><b>Steel - Bethlehem</b></p>	
<p>11. BIRTHPLACE (State or foreign country)</p> <p><b>Maryland</b></p>		<p>12. CITIZEN OF WHAT COUNTRY?</p> <p><b>USA</b></p>	
<p>13. FATHER'S NAME</p> <p><b>Henry Joseph Brunner</b></p>		<p>14. MOTHER'S MAIDEN NAME</p> <p><b>Anne Neels</b></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p> <p><b>XXXXXX WW2</b></p>		<p>16. SOCIAL SECURITY NO.</p> <p><b>218-07-8759</b></p>	<p>17. INFORMANT ADDRESS</p> <p><b>Mrs. Catherine W. Brunner 133 N. Highland Ave.</b></p>
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p><b>57181 Nutritional cirrhosis of liver</b></p>		<p>CAUSE OF DEATH</p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</p> <p><b>acute</b></p>	
<p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p><b>(C) Pulmonary edema and congestion</b></p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION</p> <p><b>2</b></p>	<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	<p>20A. AUTOPSY? (Yes or No)</p> <p><b>Yes</b></p>	<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>
<p>21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)</p>	<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p>	<p>21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <b>9-27-72</b> to <b>9-27-72</b>, that (I) (we) last saw the deceased alive on <b>9-27-72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE</p> <p><b>Allen S. Glushakow</b></p>		<p>Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/></p>	<p>23B. DATE SIGNED</p> <p><b>9-27-72</b></p>
<p>23C. PHYSICIAN'S NAME (Type)</p> <p><b>AS GLUSHAKOW</b></p>		<p>23D. ADDRESS</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify)</p> <p><b>Burial</b></p>	<p>24B. DATE</p> <p><b>9/30/72</b></p>	<p>24C. NAME OF CEMETERY OR CREMATORY</p> <p><b>Cedar Hill Cemetery</b></p>	<p>24D. LOCATION (City, town, or county) (State)</p> <p><b>Baltimore, Maryland</b></p>
<p>25A. DATE REC'D BY HEALTH DEPT.</p> <p><b>OCT 2 1972</b></p>	<p>25B. NAME OF REGISTRAR</p> <p><b>John A. Moran, Inc.</b></p>	<p>25C. FUNERAL DIRECTOR</p> <p><b>John A. Moran, Inc.</b></p>	<p>ADDRESS</p> <p><b>3000 E. Baltimore St. Baltimore, Md. 21224</b></p>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 09357</u> STATE OF MARYLAND-DEATH		
1. NAME OF DECEASED (Type or Print) <div style="text-align: center;">Helen J. Johnson</div>		2. DATE AND HOUR OF DEATH <div style="text-align: center;">9/25/1972</div>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <div style="text-align: center;">115 E. Melrose Ave</div>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY <div style="text-align: center;">Md. Baltimore</div>			
5. SEX Female			6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 9/11/1893			9. AGE (In years last birthday) 79		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pa.	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Sylvester Mahan			
14. MOTHER'S MAIDEN NAME Hannah McCullough			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO. 213 50 6910			17. INFORMANT ADDRESS Louis M. Johnson 8114 Conduit Rd			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH <i>Arterio Sclerosis of Coronary Vessels</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
19. DATE OF OPERATION			19A. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>June 6</u> 19 <u>50</u> to <u>Apr 25</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>Sept 19</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.						
23A. SIGNATURE <i>Thomas L. Wansley</i>			23B. DATE SIGNED 9/26/72		23C. PHYSICIAN'S NAME (Type) DEGREE	
23D. ADDRESS DEGREE			24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 9/27/72			24C. NAME of CEMETERY or CREMATORY Moreland Memorial		24D. LOCATION (City, town, or county) (State) Taylor Ave Balto Md.	
25A. DATE REC'D BY HEALTH DEPT. OCT 2 1972			25B. NAME OF FUNERAL HOME <i>Arthur J. Wiedefeld</i>		25C. FUNERAL DIRECTOR ADDRESS Mitchell Wiedefeld Home 6500 York Rd.	

Md.

Taylor Ave Balto

Moreland Memorial

9/27/75

Burial

Mitchell Wiedefeld Home 6500 York Rd.

James L. Wiedefeld  
Apr 14 15  
Apr 22 15  
4/26/75

William Wiedefeld

no

213 50 6010

Louis M. Johnson 8114 Conduit Rd

Sylvester Mahan

Hannah McCullough

Homemaker

Pa.

USA

79

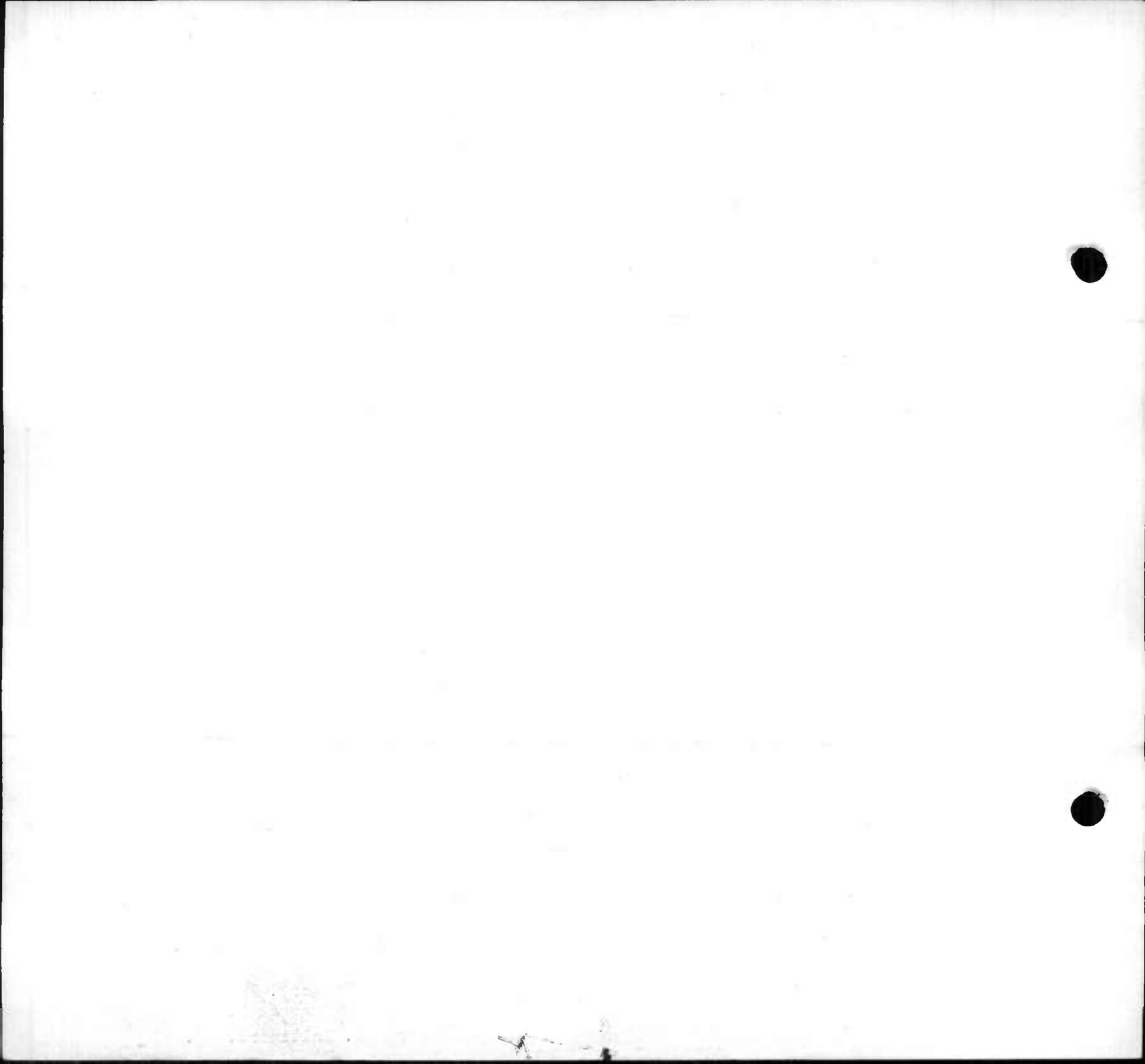
1893

6 20 0.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <span style="font-size: 1.2em;">72 09358</span>
BIRTH NO. <span style="font-size: 1.5em;">A-430</span>		72 09358		
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Mamie L. Alheit</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">Sept. 28, 1972</span> <span style="float: right;">11:00 <small>a.m.</small></span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.5em;">00</span> <span style="font-size: 1.2em;">2737 Pelham Avenue Baltimore, Md. 21213</span>		A. STATE <span style="font-size: 1.2em;">Maryland</span> 21213 C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span> E. STREET AND NUMBER <span style="font-size: 1.2em;">2737 Pelham Avenue</span>		
5. SEX <span style="font-size: 1.2em;">Female</span>		6. RACE <span style="font-size: 1.2em;">Caucasian</span>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Homemaker</span>		10B. KIND OF BUSINESS OR INDUSTRY ---		8. DATE OF BIRTH <span style="font-size: 1.2em;">Jan. 8, 1881</span>
13. FATHER'S NAME <span style="font-size: 1.2em;">Charles Lederer</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Elizabeth Reeb</span>		9. AGE (In years last birthday) <span style="font-size: 1.2em;">91</span>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		16. SOCIAL SECURITY NO. ---		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Baltimore, Maryland</span>
17. INFORMANT <span style="font-size: 1.2em;">Kathleen Durham (Daughter)</span>		ADDRESS <span style="font-size: 1.2em;">Same</span>		
18. <span style="font-size: 1.5em;">4/2/41</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <span style="font-size: 1.2em;">Arteriosclerotic cardiovascular disease</span> (A) IMMEDIATE CAUSE <span style="font-size: 1.2em;">disease</span> DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">15 yrs</span>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">No</span>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">January 1972</span> to <span style="font-size: 1.2em;">Sept 28, 1972</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">September 28, 1972</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <span style="font-size: 1.2em;">Dr. Allan A Spier</span>		23B. DATE SIGNED <span style="font-size: 1.2em;">9/29/72</span>		23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Dr. Allan A Spier</span>
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">9/30/72</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Parkwood Cemetery</span>
24D. LOCATION <span style="font-size: 1.2em;">Baltimore, Maryland</span>		25A. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Eugenia K. Seitz</span> ADDRESS <span style="font-size: 1.2em;">5209 York Rd. Baltimore, Md. 21212</span>		
25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Sidney H. Weston</span>		25C. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">OCT 2 1972</span>		





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
K-514		72 09359		72 09359	
1. NAME OF DECEASED				2. DATE AND HOUR OF DEATH	
ULYSSES GRANT KIMBLE				9-27-72 7-35 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
LUTHERAN HOSPITAL OF MARYLAND 46				MARYLAND Baltimore 5300	
5. SEX				6. RACE	
Male				White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH	
				7-2-07	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				9. AGE (In years last birthday)	
Retired Machinist				65	
10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)	
General Refractories Inc.				West Virginia	
13. FATHER'S NAME				12. CITIZEN OF WHAT COUNTRY?	
George Kimble				U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.	
Yes W W II					
17. INFORMANT				ADDRESS	
Lohr Funeral Home, Kerens Ave. at 1st St.				Elkins, W. Va.	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				3 hours	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
9-25-72				Injured lymphadenopathy	
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
yes				yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED	
				While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?					
22. I certify that (if) (this hospital) attended the deceased from 9-23-72 to 9-27-72 that (if) (we) last saw the deceased alive on 9-27-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (if) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
[Signature]				9-28-72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
M. A. ANWIK M.D.				Lutheran Hospital of Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		10-1-1972		Elkins Odd Fellows Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
OCT 2 1972		Sidney H. Hubbert		Howard H. Hubbard	
				ADDRESS	
				4107 Wilkens Ave. 21229	

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72 09360

STATE OF MARYLAND - DEPT.  
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 09360

BIRTH NO.

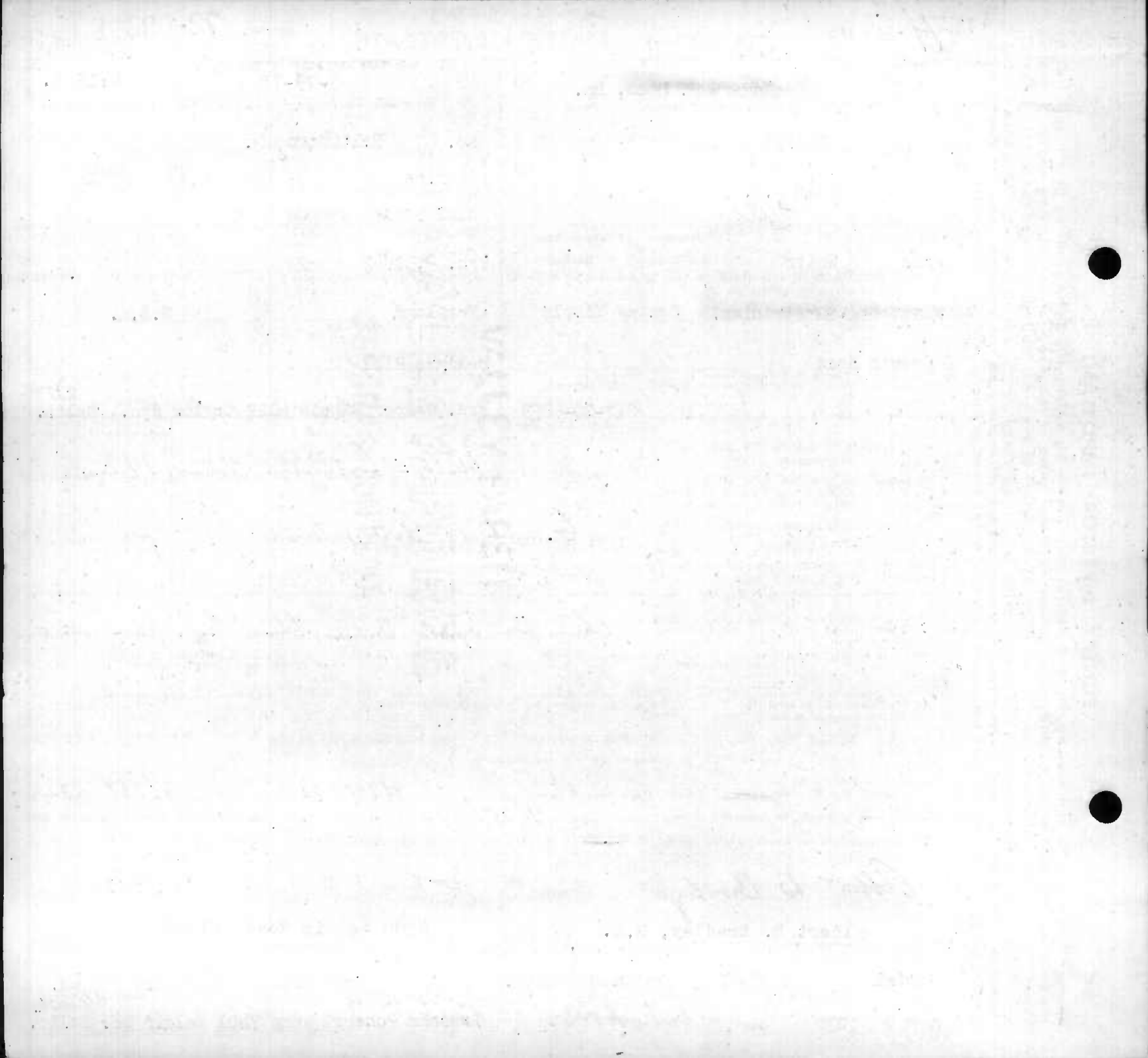
1. NAME OF DECEASED (Type or Print) Nancy Little				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month 9	Day 27	Year 72	Hour 1:26 P.	M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 712 Beaverbrook Road				3. DATE PRONOUNCED DEAD		Month 9	Day 27	Year 72	Hour 1:26 P.	M.
6. SEX Female				7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) A. STATE Maryland		B. COUNTY 2778
9. DATE OF BIRTH 9-13-43				10. AGE (in years last birthday) 29		11. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) Baltimore, Md.				12. CITIZEN OF WHAT COUNTRY? USA		E. STREET AND NUMBER 712 Beaverbrook Road				
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Technician				14B. KIND OF BUSINESS OR INDUSTRY Library		13. FATHER'S NAME R. Hamilton Little				
15. MOTHER'S MAIDEN NAME Margaret L. Knight				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				17. SOCIAL SECURITY NO. 215-42-9108		18. INFORMANT ADDRESS Irene Hurst, Darlington, Md.
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Barbiturate intoxication (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) Yes		
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? 712 Beaverbrook Road 2778				
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 9-26 or 9-27-72 ?				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Took overdose				
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <i>Marvin S. Platt</i> M.D. EXAMINER'S NAME (Type) Marvin S. Platt, M.D. DATE SIGNED 9-28-72										
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-30-1972		24C. NAME of CEMETERY or CREMATORY Darlington		24D. LOCATION (City, town, or county) (State) Darlington Harford Md.				
25A. DATE REC'D BY HEALTH DEPT. OCT 2 1972		25B. NAME OF REGISTRAR Sidney H. Harkins		25C. FUNERAL DIRECTOR ADDRESS John H. Harkins, Delta, Pa.						

10-12-1972 - Completion of cause of death on a pending medical examiner death certificate  
Marvin S. Platt, M.D. HRS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 09361</b>	
H-200 72 09361				STATE OF MARYLAND-DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Edward H. Hess, Sr.		9-29-72 4:15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  90 Gould N.H.			A. STATE Md. Baltimore		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Overlea		
			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
			E. STREET AND NUMBER 4122 Taylor Avenue		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Male	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Feb. 9, 1882	90	Maintenance Electrician
11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Maryland			U.S.A.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Joseph Hess			Belinda Hill		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
No			217-20-9453		
17. INFORMANT			ADDRESS		
Mrs. Casper Sipple			4122 Taylor Ave., Balto. 21236		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			Multiple Coronary Arteries 14 days		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Generalized Arteriosclerosis years		
			(C).....		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
Chronic Bronchopneumonia; Diabetes; Chronic Exaggerated Reflexes					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		White <input type="checkbox"/> Not White <input type="checkbox"/> Work <input type="checkbox"/> At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 8/29/1972 to 9/29/1972, that (I) (we) last saw the deceased alive on 9/25/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Albert B. Bradley				9/29/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Albert B. Bradley, M.D.				4900 Belair Road 21206	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		10/2/72		Parkwood Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
OCT 2 1972		A. S. S. S.		Lassan Funeral Home	
				ADDRESS 21236	
				7401 Belair Rd. Balto.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

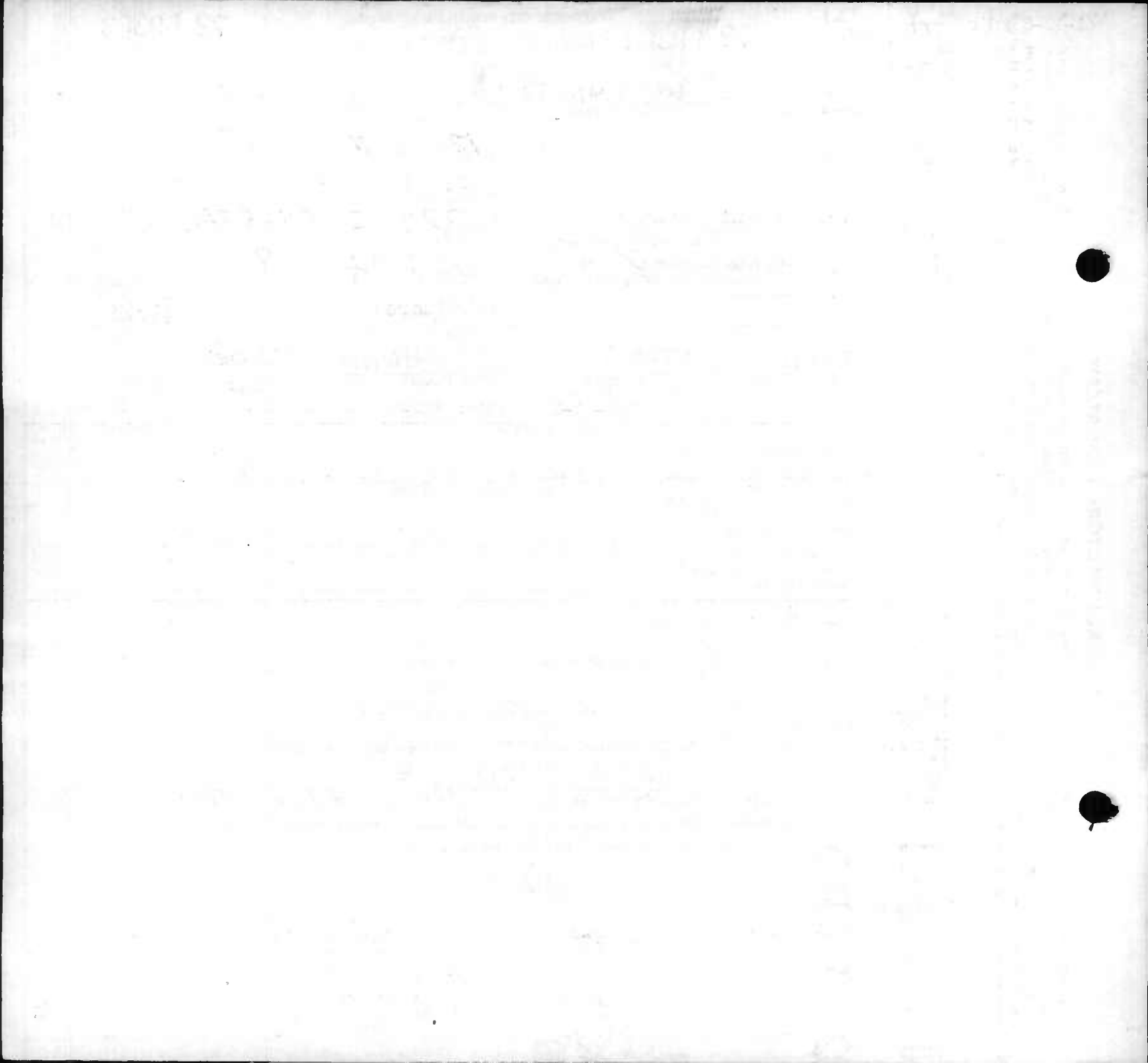
<b>6-355</b> <b>72 09362</b> <b>BALTIMORE CITY HEALTH DEPARTMENT</b> <b>CERTIFICATE OF DEATH</b>		REG. NO. <b>72 09362</b> <b>STATE OF MARYLAND - DEPT.</b>	
BIRTH NO. _____ 1. NAME OF DECEASED (Type or Print) <b>THOMAS GOADMAN</b>		2. DATE AND HOUR OF DEATH <b>Sept. 28, 1972</b> <b>9:05 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>90 HAMILTON NURSING CENTER</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____ C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3151 Elmora Ave.</b>	
5. SEX <b>male</b>	6. RACE <b>caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 6, 1886</b> 9. AGE (In years last birthday) <b>86</b> If Under 1 Yr. Months: _____ Days: _____ If Under 24 Hrs. Hours: _____ Min. _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Rail Road</b>		10B. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (State or foreign country) <b>Mississippi</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas Goadman</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Diefel</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>717-07-8729</b>	17. INFORMANT <b>Mrs. Eva Goadmah</b>
18. <b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Adeno Carcinoma prostate with generalized metastases 2 yrs.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: _____ (C) _____	
<b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION _____		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____	
20A. AUTOPSY? (Yes or No) _____		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) _____	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) (this hospital) attended the deceased from <b>9-10</b> 19 <b>72</b> to <b>9-27</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>9-27</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Dr. Sebastian Russo</b>		23B. DATE SIGNED <b>9/29 72</b>	
23C. PHYSICIAN'S NAME (Type) _____		23D. ADDRESS <b>5122 Harford Rd, Balto, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/3/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Gardens of Faith Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 2 1972</b>		25B. NAME OF REGISTRAR <b>Leonard S. Ruck, Inc.-Balto, Md.</b>	
25C. FUNERAL DIRECTOR ADDRESS _____		25D. _____	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

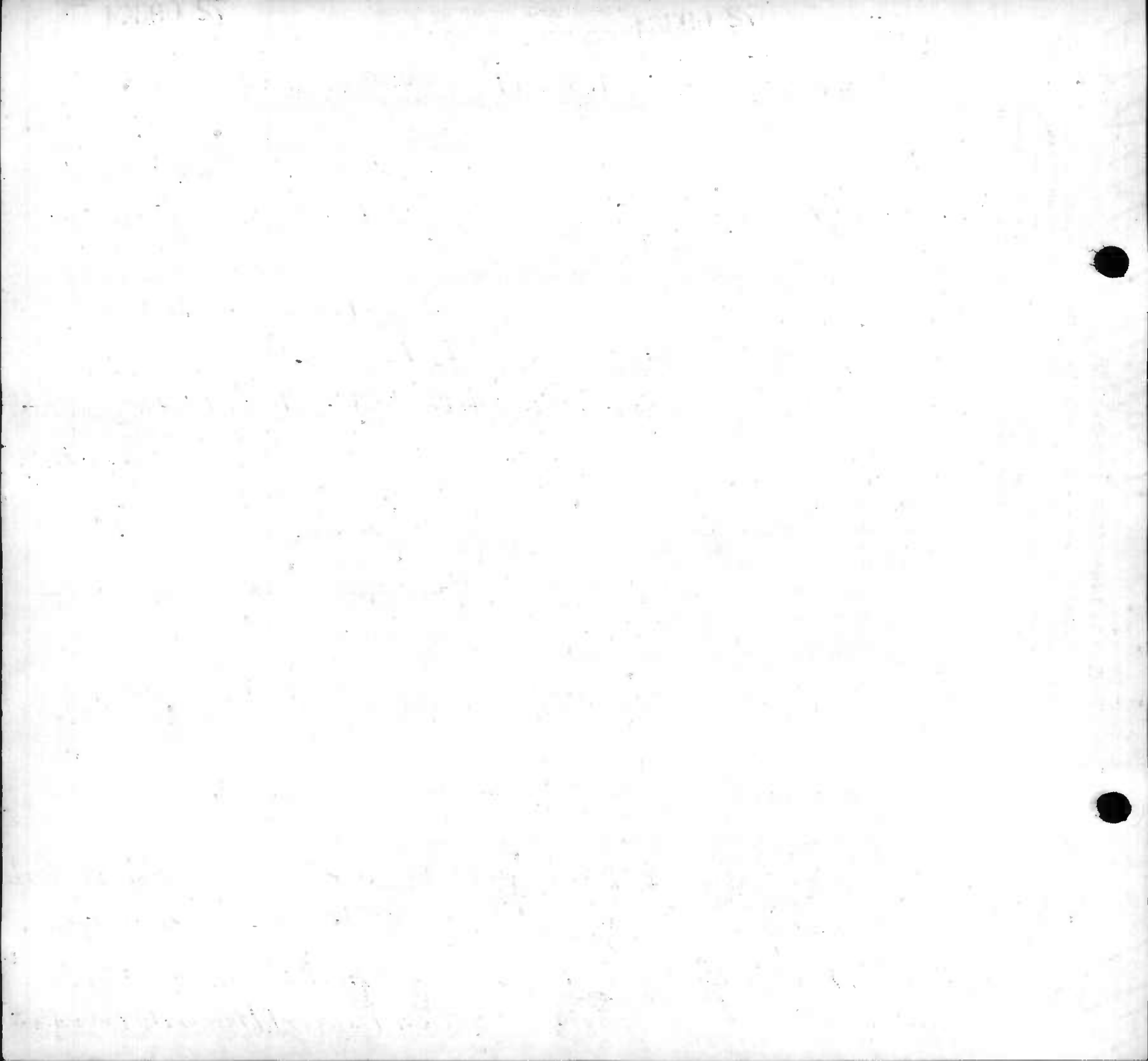
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09363	
W-655 72 09363				CERTIFICATE OF DEATH	
BIRTH NO.				STATE OF MARYLAND-DEPT	
1. NAME OF DECEASED (Type or Print) <b>PAULINE WERMINSKI</b>			2. DATE AND HOUR OF DEATH <b>September 29, 1972 11:05 A.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals</b> 4940 Eastern Avenue Baltimore, Maryland 21224			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>229 S. CHESTER ST. 21231</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/27/92</b>		9. AGE (In years last birthday) <b>80</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>	
13. FATHER'S NAME <b>MATHEW Polczynski</b>			14. MOTHER'S MAIDEN NAME <b>ANNA Glinski</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO. <b>212-07-2006D</b>		17. INFORMANT <b>4940 Eastern Avenue</b> <b>BCH: RECORDS Baltimore, Maryland 21224</b>	
18. <b>395X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Congestive Heart Failure</b> (B) <b>Rheumatic Heart Disease</b> (C) _____		
19. DATE OF OPERATION <b>2</b>			19A. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) <b>YES</b>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO</b>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>9/26</b> 19 <b>72</b> to <b>9/29</b> 19 <b>72</b> that (I) (we) lost saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Bernard Slosberg</b>				23B. DATE SIGNED <b>9/29/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>BERNARD SLOSBERG</b>				23D. ADDRESS <b>Baltimore, Maryland</b> <b>Baltimore City Hospitals 21224</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-2-72</b>		24C. NAME of CEMETERY or CREMATORY <b>Holy Rosary Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 2 1972</b>			
25B. NAME OF REGISTRAR <b>Adrian H. [Signature]</b>		25C. FUNERAL DIRECTOR <b>Mrs. Charles D. Sadowski 1931 Gough</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

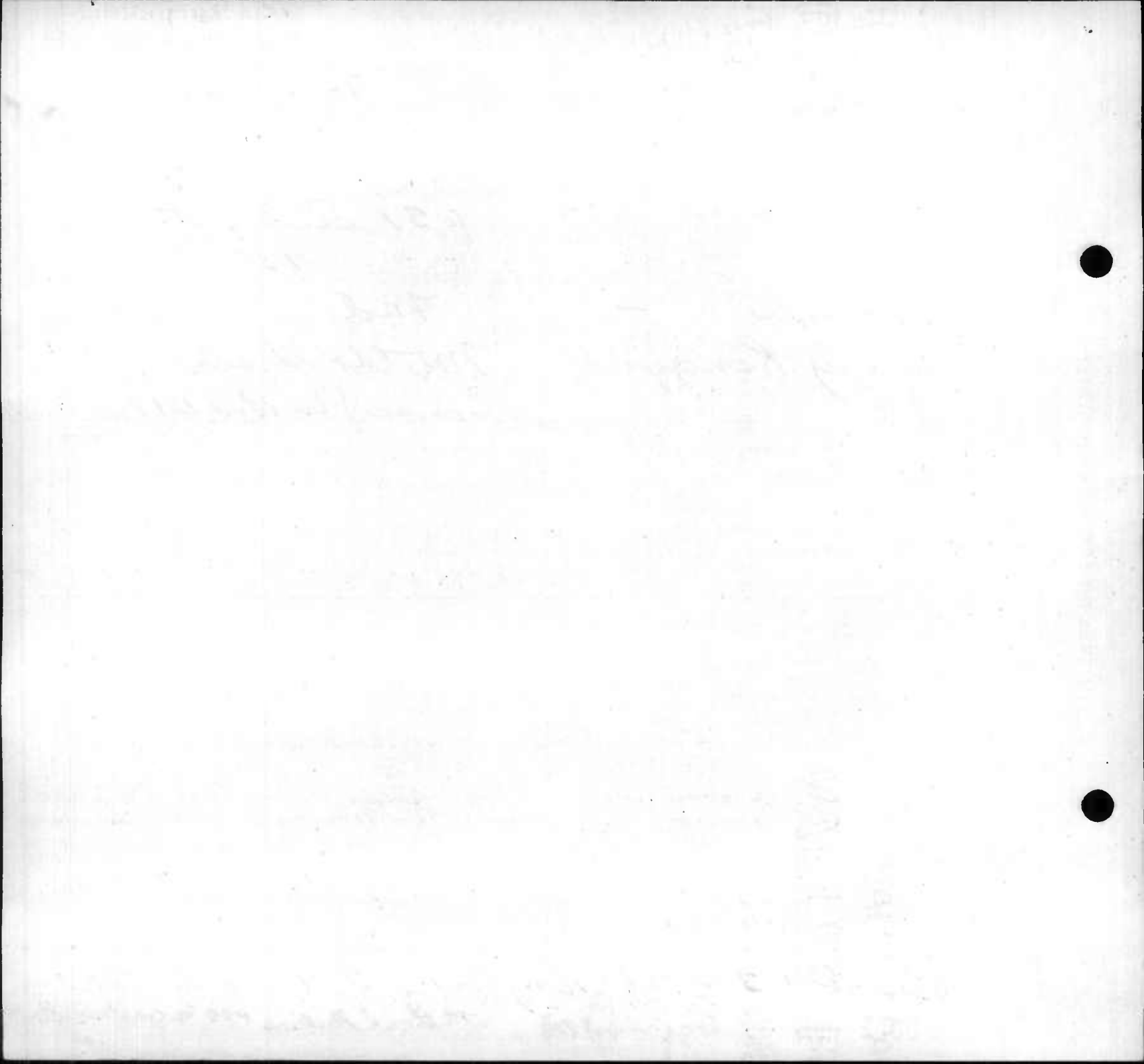
M-324		72 09364		BALTIMORE CITY HEALTH DEPARTMENT		72 09364	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.		STATE OF MARYLAND-DEMR	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
Willie M. Mitchell		9-28-72		Md.		A. STATE	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
00		3619 N. Rogers Ave.		Baito.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
M.		C.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5-13-05	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Retired - Steel Worker				S. Carolina		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
Henry Mitchell		Ida ?		No		213-09-2826	
17. INFORMANT		ADDRESS		18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Edith Mitchell		3619 N. Rogers Ave.		Myocardial Infarction		Same day	
19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (the hospital) attended the deceased from		22. I certify that (I) (the hospital) attended the deceased from		22. I certify that (I) (the hospital) attended the deceased from		22. I certify that (I) (the hospital) attended the deceased from	
that (I) (we) last saw the deceased alive on		that (I) (we) last saw the deceased alive on		that (I) (we) last saw the deceased alive on		that (I) (we) last saw the deceased alive on	
and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
H. Wasserman M.D.		Sept 30, 1972		H. Wasserman M.D.		1501 Eutaw Place Balto Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		10-2-72		MT. CALVARY Cem.		A. A. County, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
OCT 2 1972		Andrew Whitson		Elliot Funeral Home		1129 N. Caroline St.	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT		72 09365		12 09365	
BIRTH NO. <b>W-623</b>		72 09365		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>ADLINE WRIGHT</b>		2. DATE AND HOUR OF DEATH <b>9-27-72</b> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>45 The Good Samaritan Hospital</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>501</b> B. COUNTY <b>631 Sterling St.,</b> C. CITY OR TOWN <b>Balto, Md. 21202</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>631 Sterling St.</b>			
5. SEX <b>F</b>	6. RACE <b>B</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>01-13-97</b>	9. AGE (In years last birthday) <b>75</b>	10. Under 1 Yr. Months: Days: 10. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Henry Ringgold</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Grace</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Emma J. Weldon-1017 McAllister</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>01/14/250.0</b>		CAUSE OF DEATH <b>Cardiopulmonary arrest</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Probable Tuberculosis and lactic acidosis</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Diabetes mellitus</b> (C) <b>24 hr</b> <b>17 mo</b> <b>27 24 hr</b> <b>20 yr</b>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Sept 22 1972</b> to <b>Sept 27 1972</b> , that (I) (we) last saw the deceased alive on <b>Sept 27, 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>H B Thompson MD</b>		23B. DATE SIGNED <b>9/27/72</b>		23C. PHYSICIAN'S NAME (Type) <b>H B Thompson MD</b>	
23D. ADDRESS <b>1129 N. Caroline St.</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>10-3-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Int. Calvary Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>A. A. County Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 2 1972</b>		25B. NAME OF REGISTRAR <b>Audrey Whitman</b>		25C. FUNERAL DIRECTOR <b>William L. Erickson</b>	





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72 09366

STATE OF MARYLAND - DEMO  
BALTIMORE CITY HEALTH DEPARTMENT

R-320

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 09366

BIRTH NO. \_\_\_\_\_ REG. NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>WILLIAM J. RITCH (Rich)</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>46 Lutheran Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour M. <b>9 26 1972 3:30a</b>	
6. SEX <b>male</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE <b>negro</b>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>8-5-05</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years lost birthday) <b>67</b>		E. STREET AND NUMBER <b>802 N. Monroe St. 21217</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		13. FATHER'S NAME <b>William Rich</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		15. MOTHER'S MAIDEN NAME <b>Annie Barkley</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>212-36-7945</b>	
18. INFORMANT <b>Beatrice Johnson</b>		ADDRESS <b>1703 N. Castle St.</b>	
19. CAUSE OF DEATH <b>412.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>no</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Min.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>R. S. Fisher</b> M.D. EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b> DATE SIGNED <b>9-26-72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-29-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>MT. Calvary Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>A. A. County, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 2 1972</b>		25B. NAME OF REGISTRAR <b>—</b>	
25C. FUNERAL DIRECTOR <b>B/Bott Funeral Home</b>		ADDRESS <b>1129 N. Caroline St.</b>	

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William K. K.

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JESSIE JOHNSON</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 2035 Mura St.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>9 24 1972 9:15 a</b> M.	
6. SEX <b>female</b>		7. RACE <b>negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>2-24-29</b>		10. AGE (In years last birthday) <b>43</b>	
11. BIRTHPLACE (State or foreign country) <b>N. Carolina</b>		12. CITIZEN OF <b>U.S.A.</b>	
13. FATHER'S NAME <b>James L. Johnson</b>		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>808</b>	
15. MOTHER'S MAIDEN NAME <b>Joyce Jones</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO.		18. INFORMANT <b>Clifton Hargrove 2116 C. Biddle St.</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Fatty liver</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Pancreatitis</b>			
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
22A. DATE OF OPERATION <b>2</b>		22B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22C. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22D. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22E. TIME (Month) (Day) (Year) (Hour) (Approx.)		22F. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22G. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>9-25-72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-30-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt. Calvary Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>A. A. County, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT <b>OCT 2 1972</b>		25B. NAME OF REGISTRAR <b>Asst. Registrar</b>	
25C. FUNERAL DIRECTOR <b>Elbert Jones</b>		ADDRESS <b>Home 1129 N. Calvert St.</b>	

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James A. Johnson  
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James A. Johnson  
J. A. Johnson  
J. A. Johnson

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 09368</b>	
BIRTH NO. <b>72 09368</b>		STATE OF MARYLAND-DEPT	
1. NAME OF DECEASED (Type or Print) <b>JONES, Ollie (NMI)</b>		2. DATE AND HOUR OF DEATH <b>9/30/72 6:15 A. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Veterans Administration Hospital</b> <b>23 3900 Loch Raven Blvd</b> <b>Baltimore, Maryland 21218</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1601</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>717 N. Carey St.</b>	
5. SEX <b>Malr</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-15-21</b>
9. AGE (In years last birthday) <b>51</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ROCHE Jones</b>		14. MOTHER'S MAIDEN NAME <b>Clare Brown</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 8-26-42 to 10-19-45</b>		16. SOCIAL SECURITY NO. <b>226-12-6635</b>	
17. INFORMANT <b>Records</b>		ADDRESS <b>VAH, 3900 Loch Raven Blvd., Balto., Md. 21218</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>197.8 I</b> <b>Carcinoma of liver with metastasis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> <b>Hepatic coma</b> <b>Anemia 20% #1</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>?</b> <b>?</b> <b>?</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>he</del> (this hospital) attended the deceased from <b>September 1, 1972</b> to <b>September 30, 1972</b> , that <del>it</del> (we) last saw the deceased alive on <b>September 30, 1972</b> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>It</del> (We) (did) <del>not</del> view the body after death.			
23A. SIGNATURE <b>Marquette &amp; Mnaul</b>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <b>3900 Loch Raven Blvd., Balto., Md. 21218</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-3-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Phenix, Virginia</b>		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 2 1972</b>		25B. NAME OF REGISTRAR <b>Wm O March</b>	
25C. FUNERAL DIRECTOR <b>928 E North Ave.</b>		ADDRESS	

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UNITED STATES DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C.

OFFICE OF THE ASSISTANT SECRETARY FOR TECHNICAL ASSISTANCE

TECHNICAL ASSISTANCE TO THE UNITED STATES

IN THE FIELD OF AGRICULTURE

AND FORESTRY

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TECHNICAL ASSISTANCE TO THE UNITED STATES

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OFFICE OF THE ASSISTANT SECRETARY FOR TECHNICAL ASSISTANCE

WASHINGTON, D. C.

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TECHNICAL ASSISTANCE TO THE UNITED STATES

IN THE FIELD OF AGRICULTURE

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OFFICE OF THE ASSISTANT SECRETARY FOR TECHNICAL ASSISTANCE

WASHINGTON, D. C.

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TECHNICAL ASSISTANCE TO THE UNITED STATES

IN THE FIELD OF AGRICULTURE

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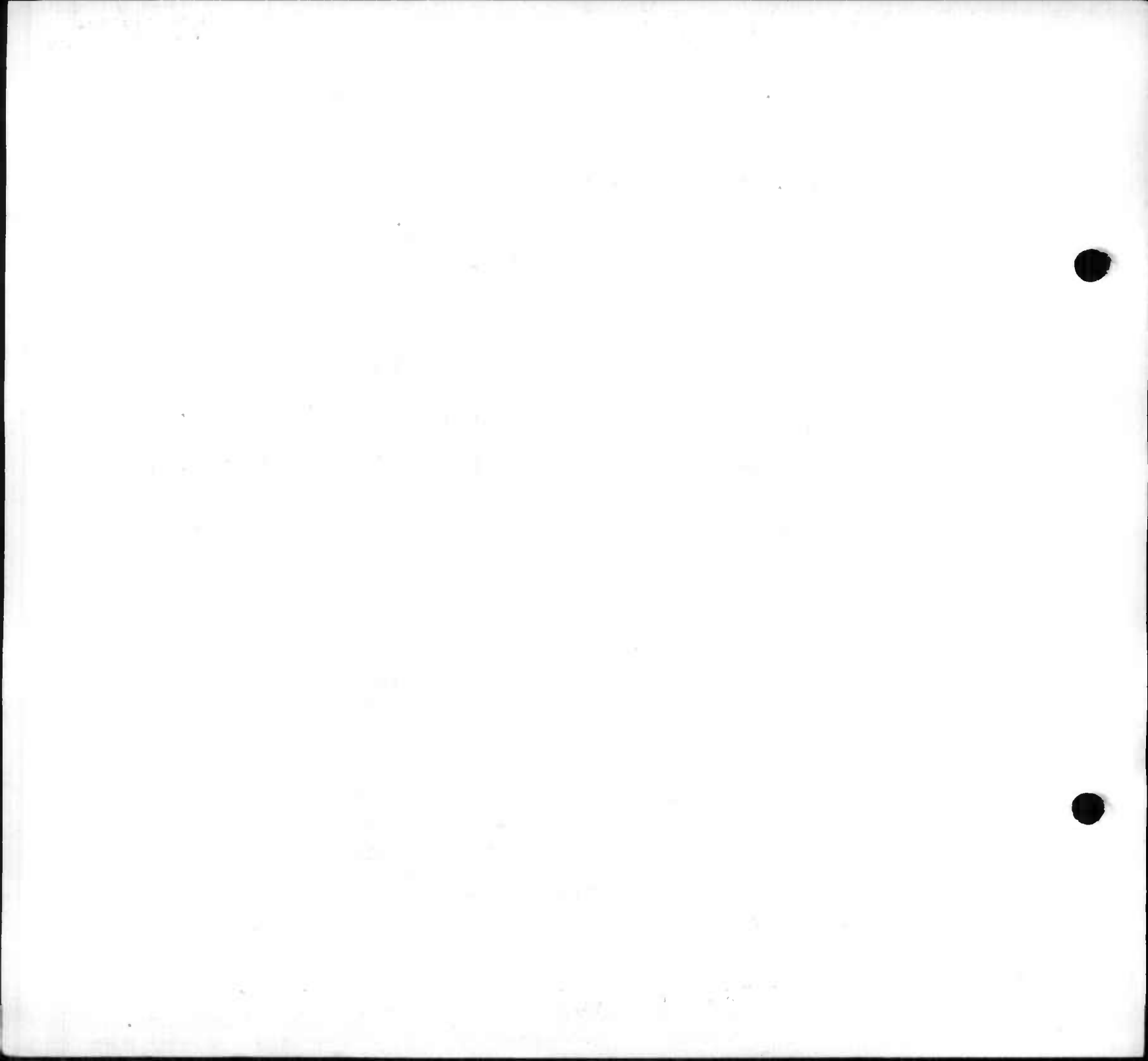


**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 09369</b>	
J-525				72 09369	
BIRTH NO.				STATE OF MARYLAND - DEPT. OF HEALTH	
1. NAME OF DECEASED (Type or Print) <b>Edna E. Johnson</b>			2. DATE AND HOUR OF DEATH <b>9-29-72 7: A M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>1500 N. Caroline Street</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>909</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1500 N. Caroline Street</b>		
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>7-26-1900</b>	9. AGE (In years last birthday) <b>72</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME <b>Levi Spence</b>
17. INFORMANT <b>Stanley Beckett</b>			ADDRESS <b>1500 N. Caroline St.</b>		
18. <b>410.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>MYOCARDIAL INFARCTION</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>HYPERTENSIVE CVDs</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11/1/1960</b> to <b>9/29/1972</b> and that (I) (we) last saw the deceased alive on <b>8/29/1972</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 			23B. DATE SIGNED <b>9/29/72</b>		23C. PHYSICIAN'S NAME (Type) <b>JOHN S. BRAXTON JR.</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>10-3-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>
24D. LOCATION <b>Balto., Md.</b>			25A. FUNERAL DIRECTOR <b>Wm C March</b>		
25B. DATE REC'D BY HEALTH DEPT. <b>OCT 2 1972</b>			25C. NAME OF REGISTRAR <b>Stanley Beckett</b>		
25D. ADDRESS <b>928 E North Ave.</b>					

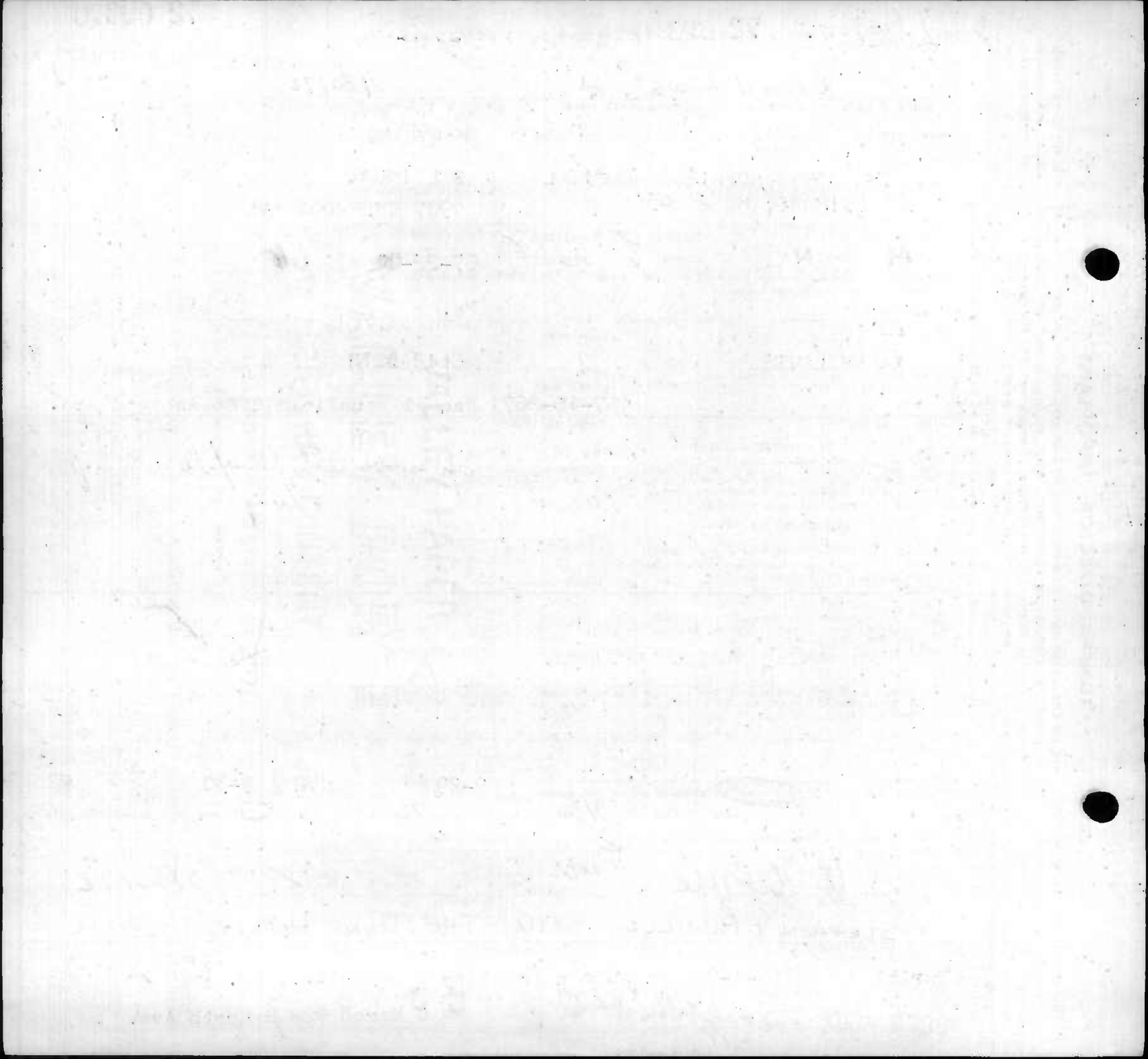




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09370		72 09370	
BIRTH NO. <span style="font-size: 1.5em;">L-200</span>				72 09370		REG. NO. <span style="font-size: 1.5em;">72 09370</span>	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
<span style="font-size: 1.5em;">Russell Laws</span>				<span style="font-size: 1.5em;">9/30/72</span>		<span style="font-size: 1.5em;">12:25 4</span> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		5. STATE	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE		B. COUNTY	
<span style="font-size: 1.5em;">33 THE JOHNS HOPKINS HOSPITAL</span>				<span style="font-size: 1.5em;">MARYLAND</span>		<span style="font-size: 1.5em;">908</span>	
<span style="font-size: 1.5em;">BALTIMORE, MD 21205</span>				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
<span style="font-size: 1.5em;">BALTIMORE</span>				E. STREET AND NUMBER		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<span style="font-size: 1.5em;">1907 SHERWOOD AVE</span>				F. AGE (In years last birthday)		G. DATE OF BIRTH	
S. SEX <span style="font-size: 1.5em;">M</span>				6. RACE <span style="font-size: 1.5em;">N</span>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
8. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. AGE (In years last birthday)		10. AGE (In years last birthday)	
<span style="font-size: 1.5em;">07-22-06</span>				<span style="font-size: 1.5em;">66</span>		<span style="font-size: 1.5em;">66</span>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<span style="font-size: 1.5em;">Laborer</span>				<span style="font-size: 1.5em;">Pa.</span>		<span style="font-size: 1.5em;">Pa.</span>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<span style="font-size: 1.5em;">Ralph Laws</span>				<span style="font-size: 1.5em;">Elizabeth</span>		<span style="font-size: 1.5em;">Elizabeth</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
<span style="font-size: 1.5em;">No</span>				<span style="font-size: 1.5em;">167-16-2671</span>		<span style="font-size: 1.5em;">Rachel Mansfield 2726 Ashland Ave.</span>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				19. CAUSE OF DEATH		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		<span style="font-size: 1.5em;">Squamous cell Ca of the lung</span>	
21. ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:		<span style="font-size: 1.5em;">2 3 yrs.</span>	
(DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
<span style="font-size: 1.5em;">2</span>				<span style="font-size: 1.5em;">Yes</span>		<span style="font-size: 1.5em;">Yes</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
<input type="checkbox"/>				<input type="checkbox"/>		<input type="checkbox"/>	
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<span style="font-size: 1.5em;">9-29</span>	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.5em;">9-29</span> 19 <span style="font-size: 1.5em;">72</span> to <span style="font-size: 1.5em;">9-30</span> 19 <span style="font-size: 1.5em;">72</span>				that (I) (we) last saw the deceased alive on <span style="font-size: 1.5em;">9/30</span> 19 <span style="font-size: 1.5em;">72</span> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		<span style="font-size: 1.5em;">9-30</span> 19 <span style="font-size: 1.5em;">72</span>	
23A. SIGNATURE				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
<span style="font-size: 1.5em;">S. V. Neville</span>				<span style="font-size: 1.5em;">9/30/72</span>		<span style="font-size: 1.5em;">STEPHEN V. NEVILLE</span>	
23D. ADDRESS				23E. ADDRESS		23F. ADDRESS	
<span style="font-size: 1.5em;">THE JOHNS HOPKINS HOSPITAL</span>				<span style="font-size: 1.5em;">THE JOHNS HOPKINS HOSPITAL</span>		<span style="font-size: 1.5em;">THE JOHNS HOPKINS HOSPITAL</span>	
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
<span style="font-size: 1.5em;">Burial</span>				<span style="font-size: 1.5em;">10-4-72</span>		<span style="font-size: 1.5em;">Mt Auburn Cemetery</span>	
24D. LOCATION (City, town, or county) (State)				24E. LOCATION (City, town, or county) (State)		24F. LOCATION (City, town, or county) (State)	
<span style="font-size: 1.5em;">Balto., Md.</span>				<span style="font-size: 1.5em;">Balto., Md.</span>		<span style="font-size: 1.5em;">Balto., Md.</span>	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
<span style="font-size: 1.5em;">OCT 2 1972</span>				<span style="font-size: 1.5em;">[Signature]</span>		<span style="font-size: 1.5em;">[Signature]</span>	
25D. ADDRESS				25E. ADDRESS		25F. ADDRESS	
<span style="font-size: 1.5em;">[Address]</span>				<span style="font-size: 1.5em;">[Address]</span>		<span style="font-size: 1.5em;">[Address]</span>	



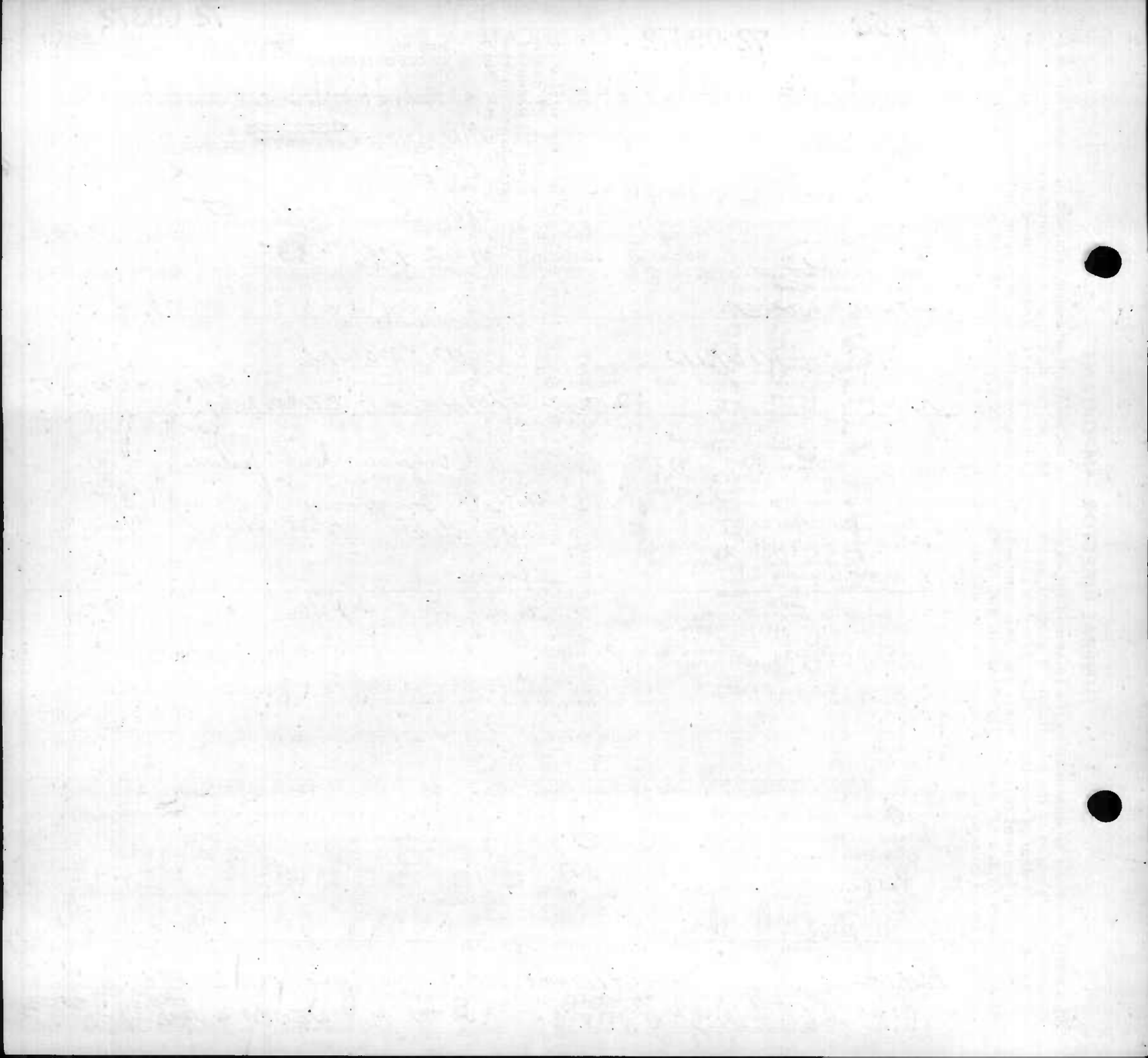
STATE OF MARYLAND-DHMH BALTIMORE CITY HEALTH DEPARTMENT				72 69371			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 72 69371			
BIRTH NO.							
1. NAME OF DECEASED (Type or Print) Richard Norris				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 9 27 72 4:28 P.M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 Johns Hopkins Hospital separated				3. DATE PRONOUNCED DEAD Month Day Year Hour 9 27 72 4:28 P.M.			
6. SEX Male				7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 7/9/28				10. AGE (In years last birthday) 44		11. BIRTHPLACE (State or foreign country) Balto., Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Howard Norris		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2664	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No			
17. SOCIAL SECURITY NO.				18. INFORMANT Mrs. Myrtle Trout same		ADDRESS	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE Multiple injuries - crushed pelvis DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? 2200 blk. Eastern Ave. near intersection of Collington Ave.	
22D. TIME OF INJURY (APPROX.) 9 27 72 3:30P				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Bicycle rider run over by tractor-trailer	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Marvin S. Platt, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) DATE SIGNED 9-28-72 ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/30/72		24C. NAME of CEMETERY or CREMATORY Oaklawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. OCT 2 1972		25B. NAME OF REGISTRAR Sidney Johnston		25C. FUNERAL DIRECTOR ADDRESS Joseph N. Zannino, 263 S. Conkling St.			

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-450		72 09372		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09372	
BIRTH NO.				STATE OF MARYLAND-DEATH			
1. NAME OF DECEASED (Type or Print) <u>TILLEN, Elizabeth</u>				2. DATE AND HOUR OF DEATH <u>9/29/72</u> <u>11:00</u> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>37 Mercy Hospital</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALTO</u> C. CITY OR TOWN <u>BALTO</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>416 S. ANN ST</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-12-1886</u>	9. AGE (In years last birthday) <u>85</u>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLOTHING WORKER.</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>NIERIN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>217-05-3274</u>		17. INFORMANT <u>HELEN CZAPKA</u> ADDRESS <u>311 S ANN ST.</u>	
18. <u>424-01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Congestive heart failure</u> (B) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Arteriosclerotic heart disease</u> (C) <u>Anemia</u> <u>Secondary Thrombocytopenia</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>years</u> <u>month</u> <u>weeks</u>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Aug 23</u> 19 <u>72</u> to <u>Sept 29</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>Sept 29</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Picavore F. Joaguin</u> M.D.				23B. DATE SIGNED <u>9-29-72</u>			
23C. PHYSICIAN'S NAME (Type) <u>NICAVORE F. JOAGUIN</u>				23D. ADDRESS <u>ST. Paul ST. (Mercy Hospital)</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>OCT 2 1972</u>		24C. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL BALTIMORE, MD.</u>		24D. LOCATION (City, town, or county) (State) <u>401 S. CHESTER ST.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 2 1972</u>				25B. NAME OF REGISTRAR <u>JOHN M. WEBER</u>		25C. FUNERAL DIRECTOR <u>JOHN M. WEBER &amp; SONS INC.</u>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72 09373
T-420 72 09373		STATE OF MARYLAND-DHMH		
1. NAME OF DECEASED (Type or Print) <u>MICHAEL Thomas TYLISZ</u>		2. DATE AND HOUR OF DEATH <u>SEPT. 30th, 1972</u>   <u>6:05 P. M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>70 Gould CONVALESCENT HOME</u>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>201</u>		
5. SEX <u>MALE</u>		6. RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>MARCH 7, 1909</u>		9. AGE (in years last birthday) <u>63</u>		10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BOARD OF RECR.</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Thomas TYLISZ</u>		
14. MOTHER'S MAIDEN NAME <u>MARGARET ? -</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>216-10-4654</u>		17. INFORMANT <u>FRANCES S. KALLER</u>		
18. <u>4/2/3 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Arteriosclerotic Heart Disease</u> (B) <u>Coronary Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>None</u>		
19. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>5/23/1972</u> to <u>9/30/1972</u> that (I) ( <del>we</del> ) last saw the deceased alive on <u>9/26/1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) (did not) view the body after death.				
23A. SIGNATURE <u>Albert B. Bradley</u>		23B. DATE SIGNED <u>9/30/1972</u>		23C. PHYSICIAN'S NAME (Type) <u>Albert B. Bradley, M.D.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>10-4-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>HOLY ROSARY CEM.</u>
24D. LOCATION (City, town, or county) <u>BALTIMORE, MD.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 2 1972</u>		
25B. NAME OF REGISTRAR <u>Sidney Johnston</u>		25C. FUNERAL DIRECTOR <u>John M. WEBER &amp; Son's</u>		
25D. ADDRESS <u>401 S. CHESTER</u>		25E. ADDRESS		



B-356

72 09374

BALTIMORE CITY HEALTH DEPARTMENT

72 09374

## CERTIFICATE OF DEATH

REG. NO.

STATE OF MARYLAND-DEATH

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MARIE E. BUETTNER

2. DATE AND HOUR OF DEATH

9-27-72 6 39 p.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)Baltimore City Hospitals  
4940 Eastern Ave.  
Baltimore, Md. 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

MD.

Baltimore

2664

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

43 Genney St.

5. SEX

Female

6. RACE

Caucasian

7. MARRIED ☐NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

2-21-04

9. AGE (In years  
last birthday)

68

11 Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

CHARLES ROBINSON  
BUETTNER

14. MOTHER'S MAIDEN NAME

Sadie Robinson -

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

218-22-4446

17. INFORMANT

4940 Eastern Ave.

ADDRESS

BCH Records: Baltimore, Md/ 21224

18. 427.4 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cardiorespiratory arrest

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Brain or Pulm. embolism

(C)

Atrial fibrillation.

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8-29-72 19 to 9-27-72 19  
that (I) (we) last saw the deceased alive on 9-27-72 19 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

Philip Smith

DEGREE

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

9-27-72

23C. PHYSICIAN'S  
NAME (Type)

PHILIP SMITH

DEGREE

23D. ADDRESS 4940 Eastern Ave. Baltimore, Md.

BALTIMORE City Hospital

24A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

10-2-72

24C. NAME OF CEMETERY or CREMATORY

BALTA NATIONAL Cem.

24D. LOCATION

(City, town, or county)

BALTO., MD.

(State)

25A. DATE OF DEATH

OCT 2 1972

25B. NAME OF DEATH

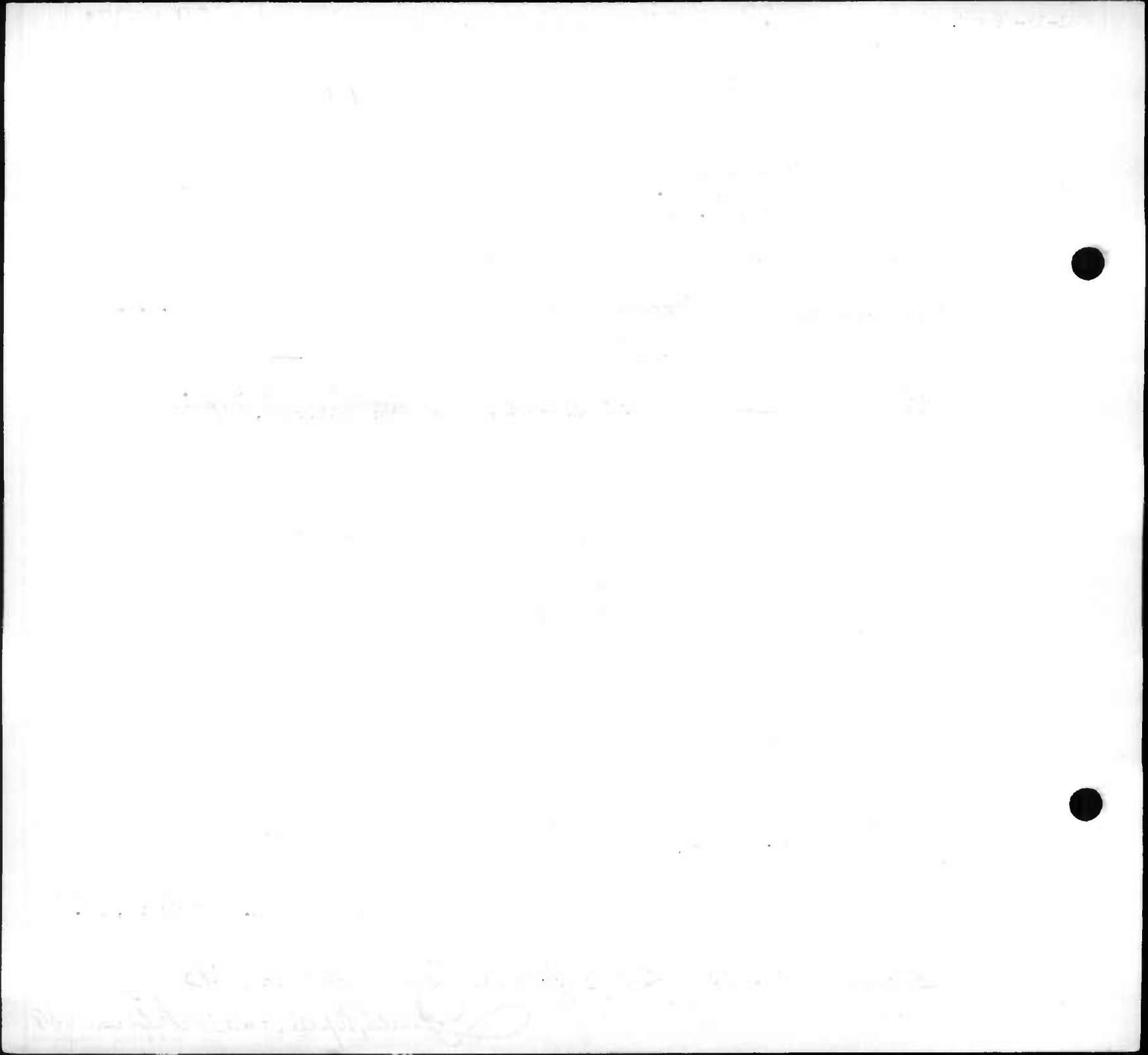
25C. FUNERAL DIRECTOR

ADDRESS

J. Smith, 2334 Jefferson St.

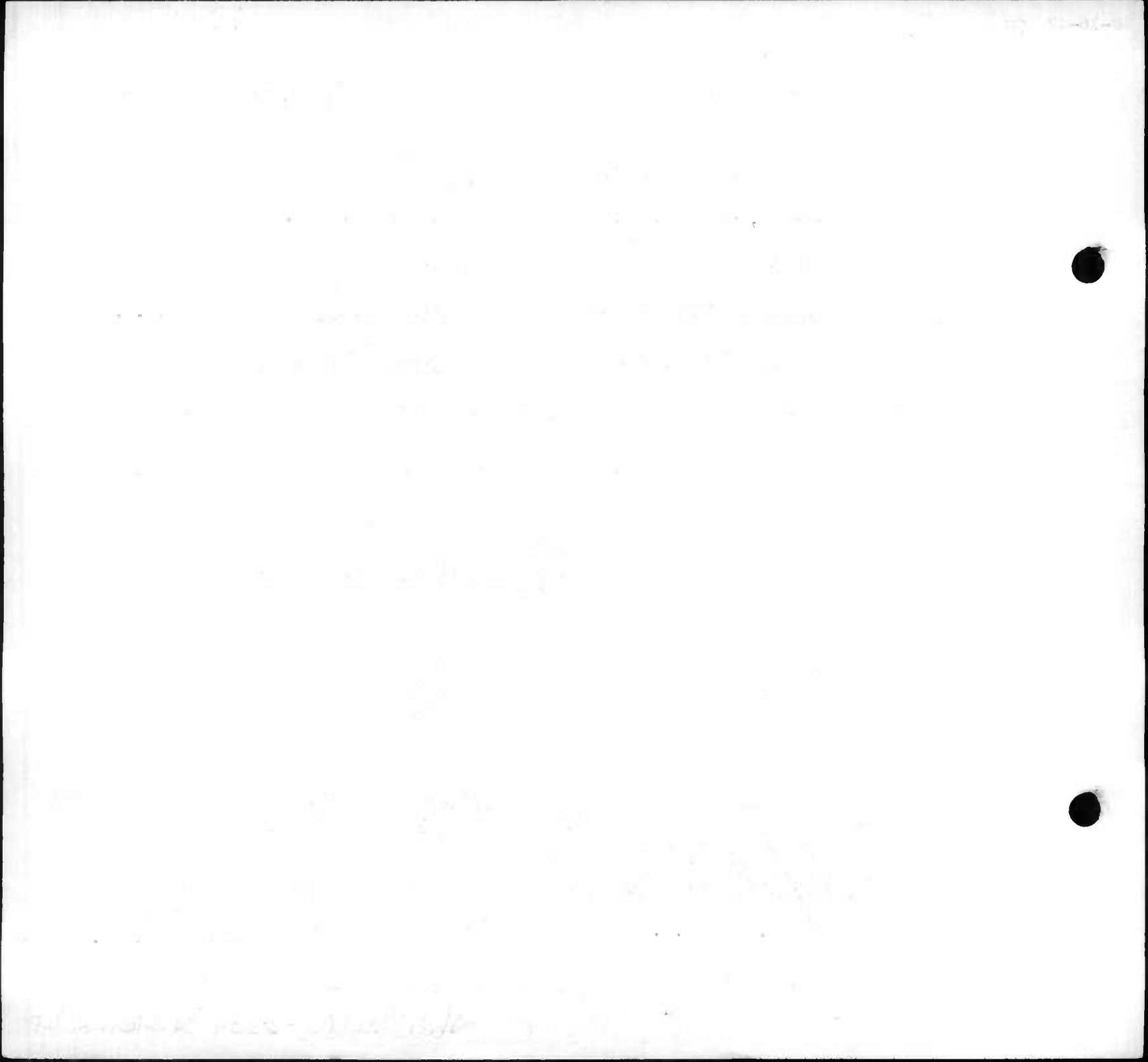
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		72 09375		REG. NO.		72 09375	
1. NAME OF DECEASED (Type or Print)		PAUL H. SPENCER		2. DATE AND HOUR OF DEATH		9/28/72		12:45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		A. STATE		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				Maryland		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Baltimore		YES <input checked="" type="checkbox"/>		NO <input type="checkbox"/>	
				E. STREET AND NUMBER		3205 Levertown Ave.		21224	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days		11. If Under 24 Hrs. Hours Min.	
Male	Caucasian	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5/12/06	66				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
WAREHOUSE MANAGER				VENETIAN BLIND CO.		MARYLAND		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
GEORGE W. SPENCER				MARY PETERS					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No				213-05-5948		BCH Records		4940 Eastern Avenue 21224	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CARDIAC ARREST				8 MINUTES	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES				(B) FOCAL PERITONITIS DUE TO, OR AS A CONSEQUENCE OF:				4 DAYS	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) CARCINOMA OF THE COLON				6 MOS +	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
9/28/72		PERFORATION OF COLON.		NO.					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from 9/28/72 to 9/28/72 that (I) (we) last saw the deceased alive on 9/28/72 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED					
Alexander M. Guba M.D.				9/28/72					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS		23E. FUNERAL DIRECTOR		ADDRESS	
				Baltimore City Hospitals		2304			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL				10-2-72		HOLY REDEEMER CEM.		BALTO., MD.	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
OCT 2 1972				Sidney Johnson		2304		Jefferson St	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72-9376	
72 09376				CERTIFICATE OF DEATH	
BIRTH NO. S-512		1. NAME OF DECEASED (Type or Print) SOPHIA ANN SIMPSON			
2. DATE AND HOUR OF DEATH 9-27-72		M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 216 N. CHESTER ST.		A. STATE MARYLAND		B. COUNTY 604	
C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 216 N. CHESTER ST.					
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-4-1879	9. AGE (In years last birthday) 92	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME BENJAMIN W. SIMPSON		14. MOTHER'S MAIDEN NAME MARY E. MEYER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-54-4205		17. INFORMANT Mrs. William H. Simpson - 216 N. Chester St.	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ANTERIOSCL. C. & D. S.		59 YEARS	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) ANTERIOSCL. GENERALIZED		109 YEARS	
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1960 to 9-27-72 that (I) <del>was</del> last saw the deceased alive on 9/25/72 and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) view the body after death.					
23A. SIGNATURE Ben. B. Moses, MD				23B. DATE SIGNED 9-29-72	
23C. PHYSICIAN'S NAME (Type) BENJ. B. MOSES, MD				23D. ADDRESS 448 N. LUZERNE AVE. BALTO. MD	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10-20-72		24C. NAME OF CEMETERY OR CREMATORY BALTIMORE CEMETERY	
24D. LOCATION (City, town, or county) BALTO., MD.		24E. LOCATION (State)			
25A. DATE REC'D BY HEALTH DEPT. OCT 2 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
25D. ADDRESS		25E. ADDRESS 2334 Jefferson St.			





**FUNERAL DIRECTOR: IMPORTANT**

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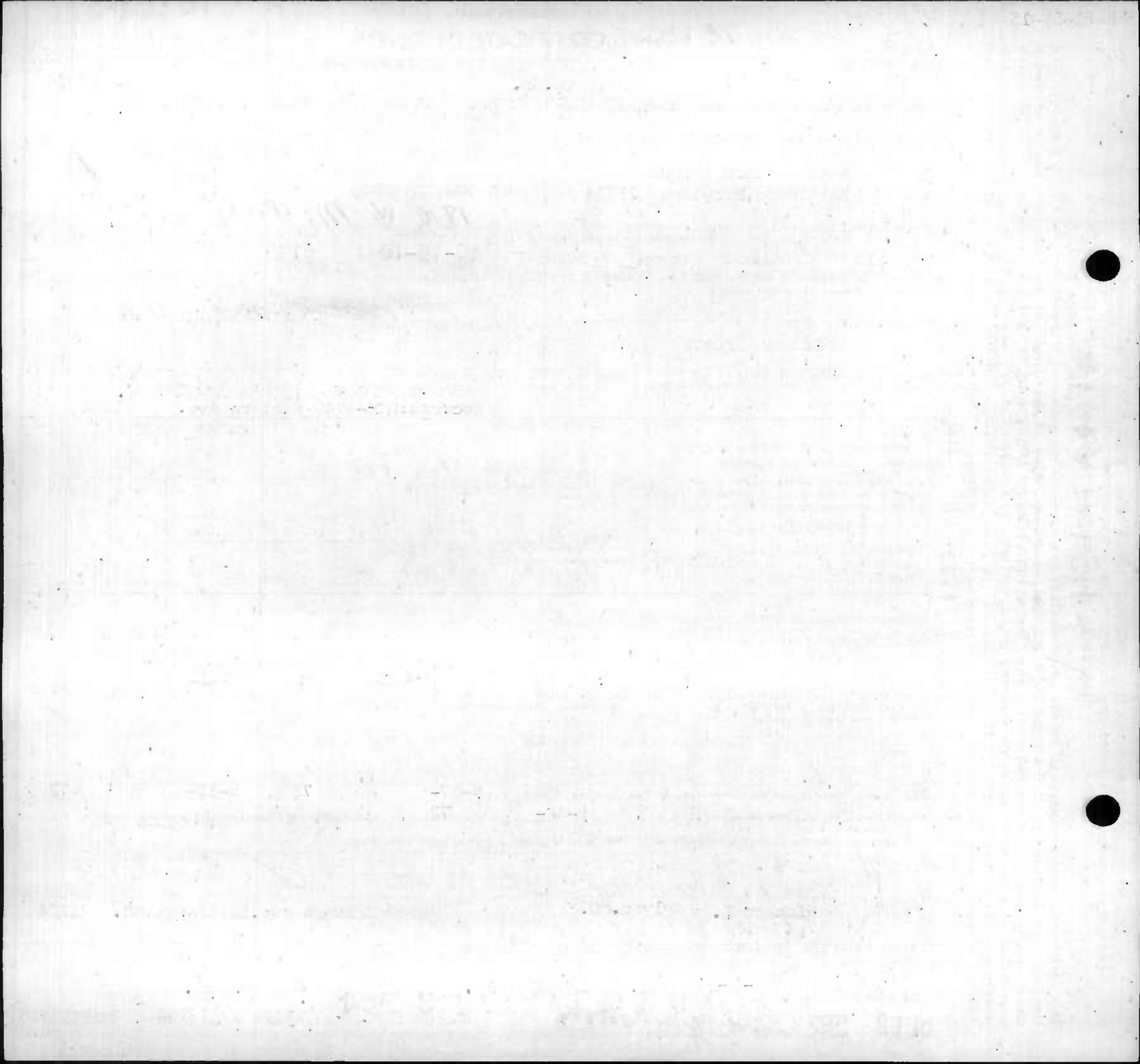
B-260 72 09377		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		72 09377
BIRTH NO.		REG. NO.		STATE OF MARYLAND-DEATH
1. NAME OF DECEASED (Type or Print) <b>BAKER, MABEL</b>		2. DATE AND HOUR OF DEATH <b>Sept. 30, 1972 6:45 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>HARFORD GARDEN'S Convalescent Home 4710 HARFORD RD.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>903</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3605 OLD YORK ROAD</b>		
5. SEX <b>F</b>	6. RACE <b>Cau.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB. 29, 1893</b>	9. AGE (in years last birthday) <b>79</b> If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MO.</b>
13. FATHER'S NAME <b>FRED EAGER</b>		14. MOTHER'S MAIDEN NAME <b>STEADMAN</b>		
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220-54-5397</b>		17. INFORMANT <b>WINFIELD BAKER 3605 OLD YORK RD</b>
18. <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Concursive Heart Failure</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerotic Cardio-vascular Disease</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Few minutes</b> <b>Several years</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>Aug. 23, 1972</b> to <b>Sept. 30, 1972</b> that (I) (we) last saw the deceased alive on <b>Sept. 11, 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE <b>M. Zimmerman M.D.</b>		23B. DATE SIGNED <b>9/30/72</b>		23C. PHYSICIAN'S NAME (Type) <b>Ray M. Zimmerman M.D.</b>
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <b>10/3/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery North Ave Baltimore</b>
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 2 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Whitman</b>		25C. FUNERAL DIRECTOR <b>Frank Cook 7700 Harford Rd.</b>



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 77-09378	
72 69378				STATE OF MARYLAND-DEME	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Anthony Brown Sr.</i>		2. DATE AND HOUR OF DEATH <i>401 PM 9/30/72 1101 P M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>BALT</i>		C. CITY OR TOWN <i>BALTIMORE</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>BALTIMORE CITY HOSPITAL</i>		5. SEX <i>Male</i> 6. RACE <i>Black</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>10-15-10</i> 9. AGE (In years last birthday) <i>61</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Walter Brown</i>		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Jerome Brown 5135 Nelson Ave. Records: BCH-4940 Eastern Ave. 21224</i>	
18. <i>185 X I</i>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <i>Resp Arrest</i> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>Metastatic CA undifferentiated</i> DUE TO, OR AS A CONSEQUENCE OF:			
(C) <i>CA of prostate known primary</i>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>9-27-</i> 19 <i>72</i> to <i>9-30-</i> 19 <i>72</i> , that (I) (we) last saw the deceased alive on <i>9-30-</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Richard L. Sylvan MD</i>		23B. DATE SIGNED <i>9/30/72</i>			
23C. PHYSICIAN'S NAME (Type) <i>Richard L. Sylvan MD</i>		23D. ADDRESS <i>4940 Eastern Ave. Baltimore, Md. 21224</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10-5-72</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Calvary Cem.</i>	
24D. LOCATION (City, town, or county) <i>Balto. Md.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 2 1972</i>		25B. NAME OF REGISTRAR <i>Dr. J. H. Nelson</i>		25C. FUNERAL DIRECTOR <i>V. Bailey</i> ADDRESS <i>1348 Calhoun Street</i>	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09379	
CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		MC CORMICK, WILLIAM JOSEPH		OCTOBER 1, 1972 9:00A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL			A. STATE MARYLAND CITY 21223		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 2518 WILKENS AVENUE 2005		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months: Days
MALE	CAUCASIAN	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	03 08 97	75	11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
SECRETARY		SAVINGS & LOAN		MARYLAND	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
JOHN MC CORMICK			HANNAH (GLOSTER)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
NO		217168272		RECORDS OF ST. AGNES HOSPITAL CATON & WILKENS AVES. BALTO., MD. 21229	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES			Pulmonary Edema		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
			Aspiration Pneumonia		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			Generalized metastatic CA		
			(C) due to Primary Adenocarcinoma Colon		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (X) (this hospital) attended the deceased from SEPTEMBER 26 19 72 to OCTOBER 1 19 72, that (X) (we) last saw the deceased alive on OCTOBER 1 19 72 and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXX) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Sergio San Pedro M. D.				10/1/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
				ST. AGNES HOSPITAL CATON & WILKENS AVES. BALTO., MD. 21229	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		10/4/72		New Cathedral Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
OCT 2 1972		George A. Weber - 705 S. Ann St. #21231			

OCTOBER 1, 1972

WILLIAM JOSEPH

11222

CITY

NEW YORK

ST. JAMES HOSPITAL

X

OCT 02 97

CAUCASIAN

MALE

NEW YORK

SAVINGS & LOAN

RECORDS

HANNAH (GLOSTER)

JOHN W. GLOSTER

ST. JAMES HOSPITAL  
CITY & WILKINS AVE., BALTO., MD. 21202



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-300		72 09380		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09380	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Scott H. Mr. Thomas				2. DATE AND HOUR OF DEATH: 10/1/72 11:20:00 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Bon Secours Hospital FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 34				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2245 W. Fayette St.			
5. SEX male	6. RACE B	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/29/10	9. AGE (in years last birthday) 62	11. BIRTHPLACE (State or foreign country) Virginia		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer			10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U.S.A		
13. FATHER'S NAME Edner Scott				14. MOTHER'S MAIDEN NAME Maggie Pryor			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 218-01-9386	17. INFORMANT Beatrice Scott. 2245 W. Fayette St.			
18. 571.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) HEPATIC COMA. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). DESCOMPENSATED LIVER CIRRHOSIS CHRONIC ALCOHOL INTAKE.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 9-19 1972 to 10-1 1972 that (I) (we) last saw the deceased alive on 9-30 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE M. Behm M.D.				23B. DATE SIGNED 10-1-72		23C. PHYSICIAN'S NAME (Type) MANUELINO F. M. BERNARDI	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/5/72		24C. NAME OF CEMETERY OR CREMATORY Baltimore Nat'l Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. OCT 2 1972		25B. NAME OF REGISTRAR Sidney H. Hinton		25C. FUNERAL DIRECTOR Charles A. Rice 1300 N. Eutaw Pl.			



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-520		72 09381		BALTIMORE CITY HEALTH DEPARTMENT		72 09381	
<b>CERTIFICATE OF DEATH</b>				REG. NO.			
1. NAME OF DECEASED (Type or Print) <b>TOWNES, WILLIAM</b>				2. DATE AND HOUR OF DEATH <b>Sept. 29 1972</b> <b>3:05 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2301</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SOUTH BALTIMORE GENERAL HOSPITAL</b> <b>43</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>M</b> 6. RACE <b>C</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>1-8-50</b> 9. AGE (In years last birthday) <b>24</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>N.C.</b>	
13. FATHER'S NAME <b>Thomas Townes</b>				14. MOTHER'S MAIDEN NAME <b>Katie</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service				16. SOCIAL SECURITY NO. <b>213-12-6945</b>		17. INFORMANT ADDRESS <b>Mary Harris 1103 S. Sharp St.</b>	
18. <b>412.4 I</b> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>NOT KNOWN;</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <b>probably CVA due to ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(C)			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>H. Koenen III</i>				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <b>DEGREE</b>	
23D. ADDRESS <b>DEGREE</b>				23E. FUNERAL DIRECTOR ADDRESS <b>Charles A. Rice 1300 N. Eutaw Pl.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/3/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Westport, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 2 1972</b>		25B. NAME OF REGISTRAR <i>Lidney Houston</i>		25C. FUNERAL DIRECTOR ADDRESS <b>Charles A. Rice 1300 N. Eutaw Pl.</b>			

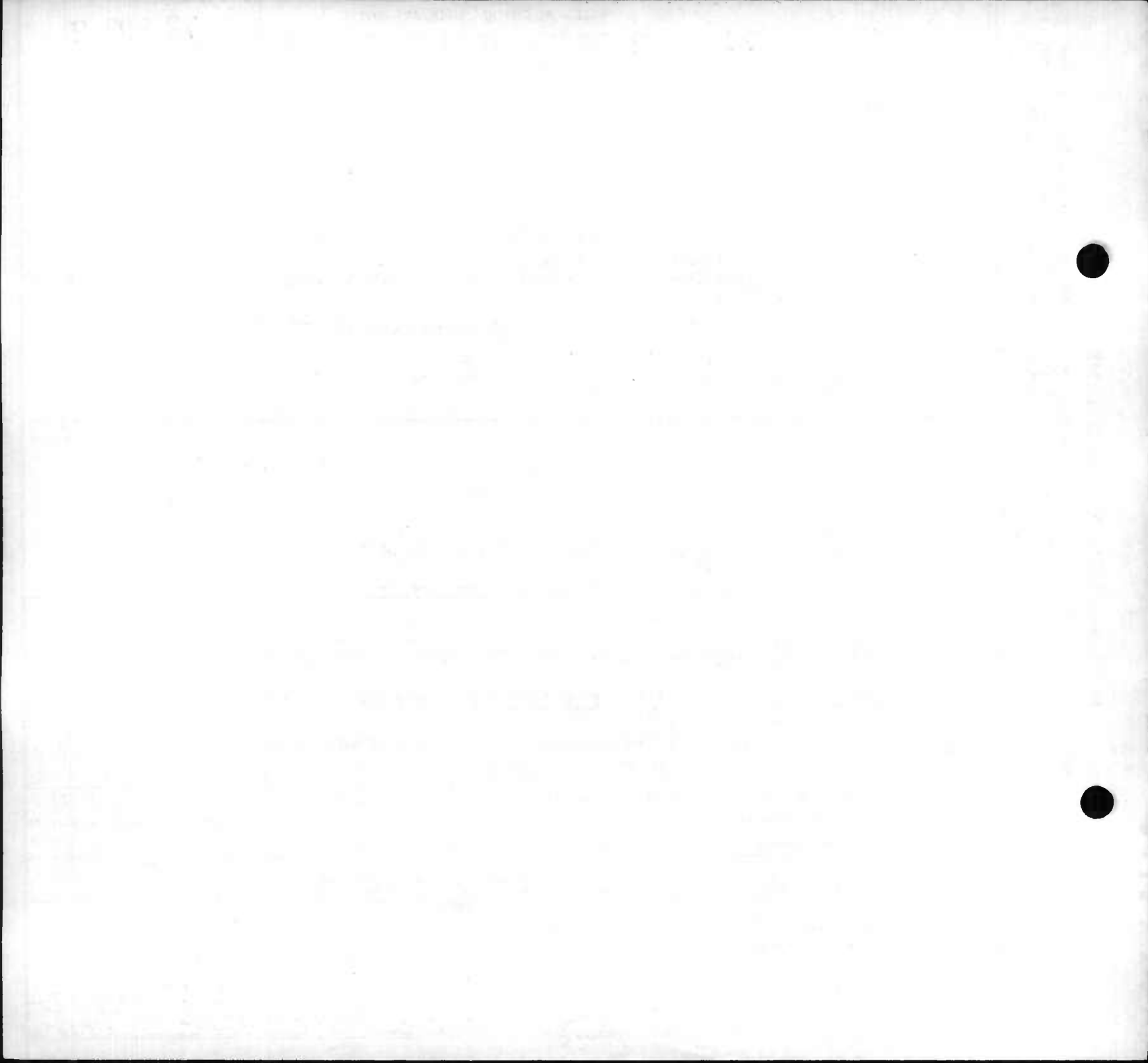
1-8-00-3-1

2-1-00-3-1

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

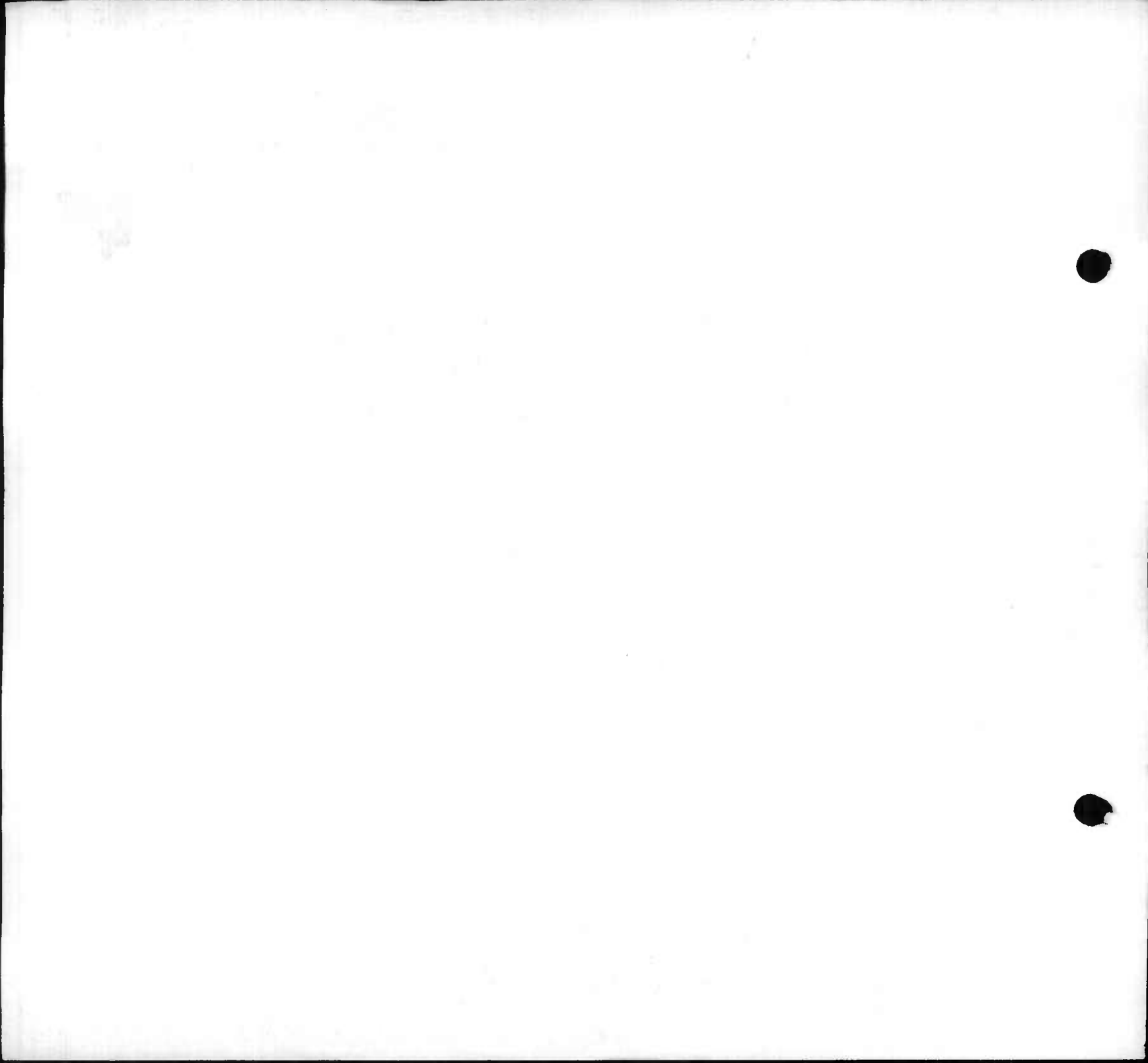
BALTIMORE CITY HEALTH DEPARTMENT		72 09382		72 09382	
BIRTH NO. <u>M-436</u>		72 09382		72 09382	
1. NAME OF DECEASED (Type or Print) <u>NORMAN MULDROW JR</u>		2. DATE AND HOUR OF DEATH <u>9/29/72</u> <u>11:50 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>MARYLAND GENERAL</u> <u>48 HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1702</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1113 TIFFANY CT.</u> <u>21201</u>			
5. SEX <u>M</u>	6. RACE <u>B</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/16/23</u>	9. AGE (in years last birthday) <u>48</u>	10. Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TICKET TAICER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>THEATRE</u>		11. BIRTHPLACE (State or foreign country) <u>SO. CAROLINA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>NORMAN MULDROW SR</u>			
14. MOTHER'S MAIDEN NAME <u>EMMA LUNN</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>1/1946 - 3/2/1947</u>			
16. SOCIAL SECURITY NO. <u>218-12-7593</u>		17. INFORMANT <u>WIFE</u> ADDRESS <u>LILLIE MAE MULDROW. SAME</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>162.1 I</u> <u>RESPIRATORY ARREST</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>OAT CELL CARCINOMA, LUNG.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9/29</u> <u>1972</u> to <u>9/29</u> <u>1972</u> that (I) (we) last saw the deceased alive on <u>9/29</u> <u>1972</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Artemio M. Cuevas Jr MD</u>		23B. DATE SIGNED <u>9/29/72</u>		23C. PHYSICIAN'S NAME (Type) <u>ARTEMIO M. CUEVAS JR MD</u>	
23D. ADDRESS <u>MARYLAND GENERAL HOSP.</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>10-3-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 2 1972</u>		25B. NAME OF REGISTRAR <u>Artemio M. Cuevas Jr</u>		25C. FUNERAL DIRECTOR <u>Artemio M. Cuevas Jr</u>	
25D. ADDRESS <u>1701 Laurens St.</u>					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09383		REG. NO. 72 09383	
K-200				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Keys, Wendell Sr.</u>				2. DATE AND HOUR OF DEATH <u>9/30/72</u> <u>1:30 P</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Univ. of Md. Hospital</u> <u>38</u>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>St. Mary's</u>			
				C. CITY OR TOWN <u>Balt.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>1707 W. Fayette</u> <u>1901</u>			
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-12-13</u>	9. AGE (In years last birthday) <u>59</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Houseman</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Amer. Copperage</u>		11. BIRTHPLACE (State or foreign country) <u>Saluda, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Wendell Keys</u>			14. MOTHER'S MAIDEN NAME <u>Anna Keys</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>218-10-5096</u>		17. INFORMANT <u>Wendell Keys</u>		ADDRESS <u>4931-Edmore Ave</u>
18. <u>513 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <u>Acute Pulmonary Hemorrhage</u> 10 min DUE TO, OR AS A CONSEQUENCE OF:  (B) <u>Long Abscess</u> DUE TO, OR AS A CONSEQUENCE OF:  (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>8-13</u> 19 <u>72</u> to <u>9-30</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>9-30</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>C. A. Galloway</u>				23B. DATE SIGNED <u>9-30-72</u>		23C. PHYSICIAN'S NAME (Type) <u>Galloway</u>	
23D. ADDRESS <u>Univ. of Md. Hospital</u>				23E. DATE OF OPERATION <u>2</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>10-5-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 2 1972</u>		25B. NAME OF REGISTRAR <u>Sidney [Signature]</u>		25C. FUNERAL DIRECTOR <u>Robert J. Dyett</u>		25D. ADDRESS <u>F.H. 1701-1705</u>	

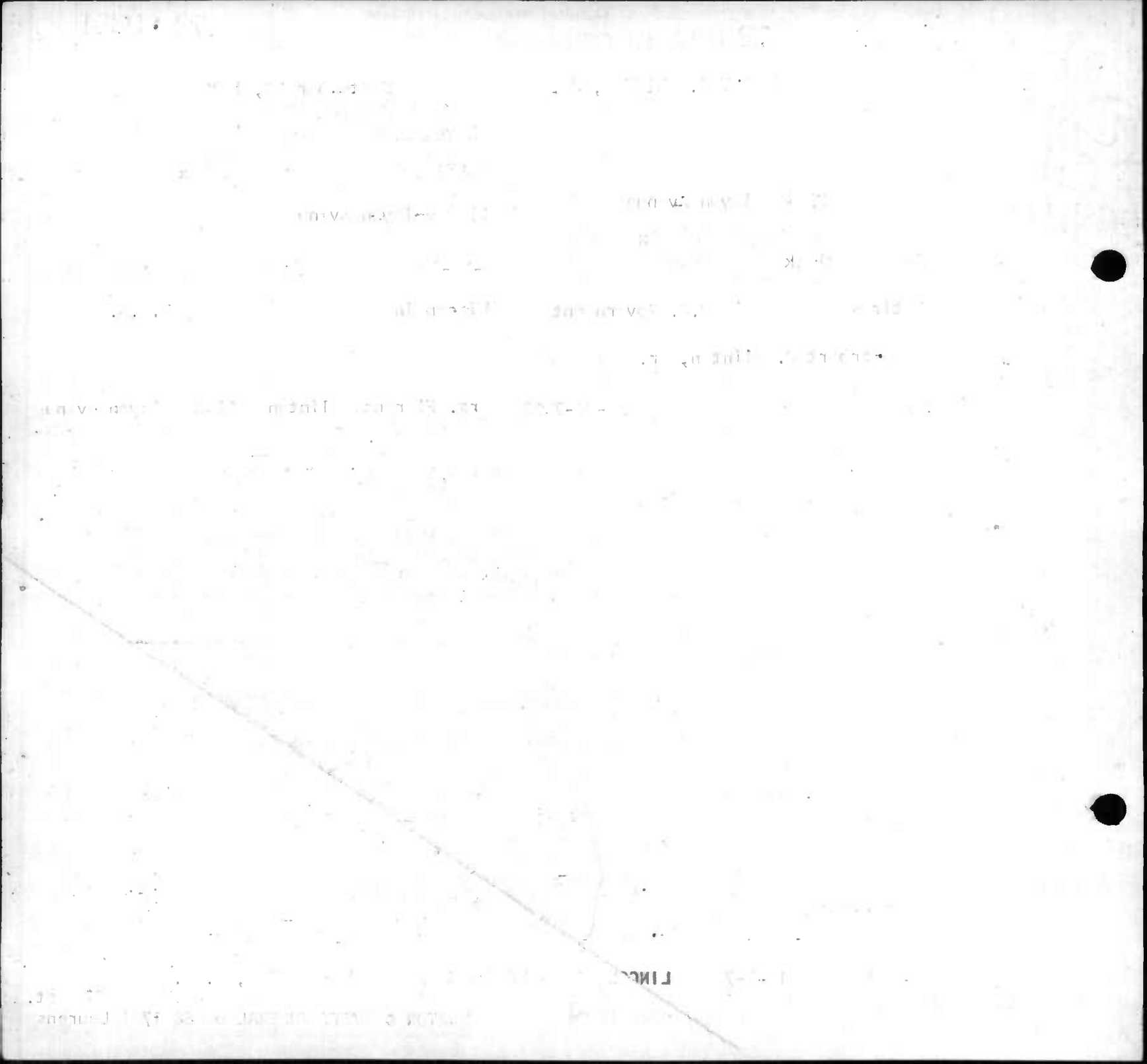




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09384		STATE OF MARYLAND - DHMH	
C-453		72 09384		72 09384		72 09384	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
HERBERT J. CLINTON, JR.				September 29, 1972			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  00 2304 Halcyon Avenue				A. STATE MARYLAND		B. COUNTY 2733	
				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 2304 Halcyon Avenue							
5. SEX Male	6. RACE Black	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-25-14	9. AGE (In years last birthday) 58	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Herbert J. Clinton, Sr.				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. 058-01-7023		17. INFORMANT ADDRESS Mrs. Florence Clinton 2304 Halcyon Avenue			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediately	
				(B) Coronary artery disease DUE TO, OR AS A CONSEQUENCE OF:		5 yrs	
				(C) generalized arteriosclerosis			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from May 19 1972 to 9/29 1972, that (1) (we) last saw the deceased alive on 9/19 1972 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Stanley D. Madison MD				23B. DATE SIGNED 9/30/72			
23C. PHYSICIAN'S NAME (Type) Stanley D. Madison MD				23D. ADDRESS 2440 E. Biddle St. Balto, Md 21217			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10-3-72		24C. NAME of CEMETERY or CREMATORY LINCOLN MEMORIAL PARK		24D. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
25A. DATE REC'D BY HEALTH DEPT. OCT 2 1972		25B. NAME OF REGISTRAR Sidney Johnston		25C. FUNERAL DIRECTOR MORTON & DYETT FUNERAL HOMES		25D. ADDRESS 1701 Laurens St.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

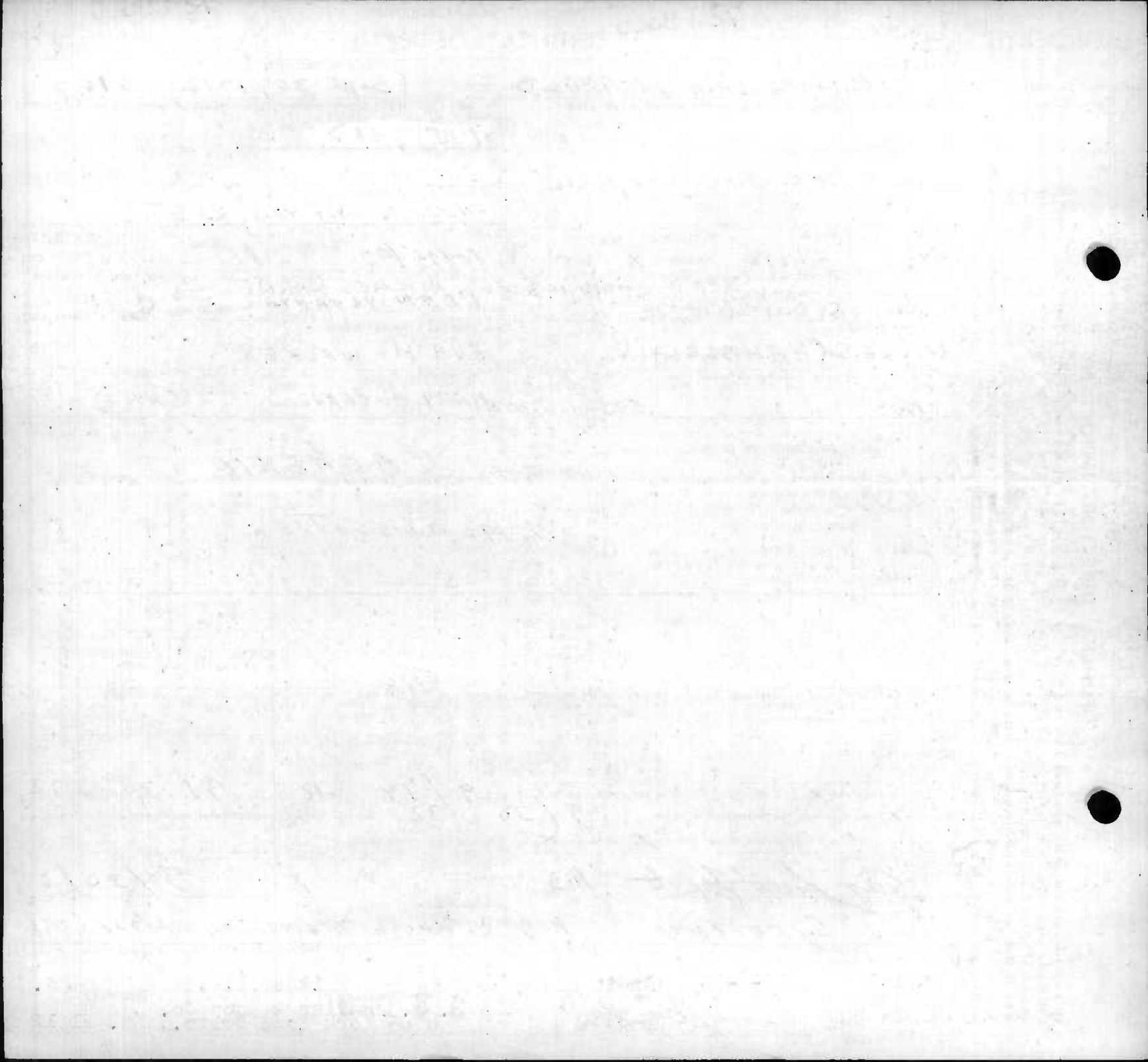
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 09385</b>	
BIRTH NO. <b>W-400</b>		72 09385	
BIRTH NO.		STATE OF MARYLAND - <del>DEPT</del>	
1. NAME OF DECEASED (Type or Print) <b>TERRY T. WILL</b>		2. DATE AND HOUR OF DEATH <b>9/30/72</b> <b>7:55</b> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTO</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>48 Md. General Hospital</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <b>3419 Cochrane Dr. 21207</b>	
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/17/23</b> 49
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD.</b>	
10B. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM O. TOWSON</b>		14. MOTHER'S MAIDEN NAME <b>CAROLINE HUTTON</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service] <b>No</b>		16. SOCIAL SECURITY NO. <b>182-22-9671</b>	
17. INFORMANT <b>DR. DAVID R. WILL (SAME)</b>		ADDRESS	
18. <b>340 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Aspiration Pneumonia</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Multiple sclerosis</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
19. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/29</b> 19 <b>72</b> to <b>9/30</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>9/30</b> 19 <b>72</b> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>James H. Biddison MD</b>		23B. DATE SIGNED <b>9/30/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>JAMES H. BIDDISON, MD</b>		23D. ADDRESS <b>Md. General Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-3-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Druid Ridge Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Pikesville, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 2 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Johnston</b>	
25C. FUNERAL DIRECTOR <b>Henry W. Jenkins</b>		ADDRESS <b>4905 York Rd. Baltimore, Md. 21212</b>	

ORIGINAL DOCUMENT

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09386		12 09386	
C-516				CERTIFICATE OF DEATH		X REG. NO. STATE OF MARYLAND-DMH	
1. NAME OF DECEASED (Type or Print) <b>CHAMBERLAIN, HAROLD</b>				2. DATE AND HOUR OF DEATH <b>Sept 30, 1972 5:10 P. M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>N.J.</b> B. COUNTY <b>V27</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hospital</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>EAST ORANGE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
15. SEX <b>M</b>		16. RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/13/1901</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED PROPRIETOR</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>R.R. SUPPLIES</b>		11. BIRTHPLACE (State or foreign country) <b>WILKES BARRE PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLES S. CHAMBERLAIN</b>				14. MOTHER'S MAIDEN NAME <b>EVA M. WALKER</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>093-01-3732A</b>		17. INFORMANT <b>MARY C. CRANE</b>		ADDRESS <b>(SAME)</b>	
18. <b>269.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CACHEXIA</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>MALABSORPTION</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>9/14 1972</b> to <b>9/30 1972</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>9/30 1972</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Luis Sirotzky M.D.</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>9/30/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Luis Sirotzky M.D.</b>				23D. ADDRESS <b>Union Memorial Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-3-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Druid Ridge</b>		24D. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 2 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Johnston</b>		25C. FUNERAL DIRECTOR <b>B. J. Jenkins &amp; Sons Co.</b>		ADDRESS <b>4905 York Road Balto., Md. 21212</b>	

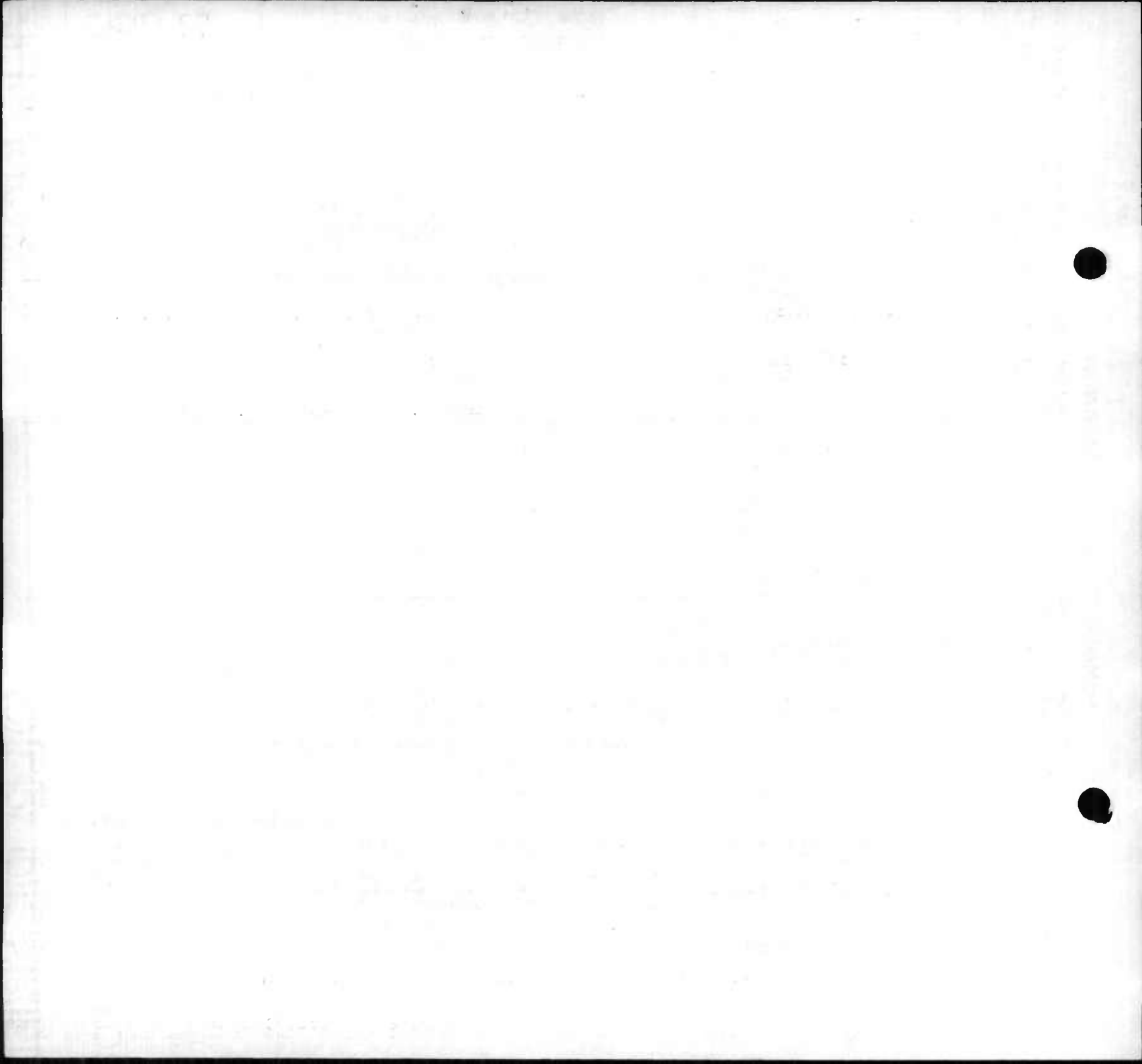




# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 09387</b>
72 19387				STATE OF MARYLAND-DEATH
BIRTH NO. <b>K-457</b>		1. NAME OF DECEASED (Type or Print) <b>William Klump</b>		
2. DATE AND HOUR OF DEATH <b>7:45 PM 9-28-72</b>		M. <b>97</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore City</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Sinai Hospital</b> <b>Belvedere &amp; Greenspring Ave</b> <b>Baltimore, Maryland 21133</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>Male</b> 6. RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-19-1896</b> 9. AGE (in years last birthday) <b>76</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Balto. City Police</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Jacob Klump</b>		
14. MOTHER'S MAIDEN NAME <b>Mary Lipp</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hilda E. Klump-3119 W. Belvedere Avenue</b>		
18. <b>436.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebrovascular Accident.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Chronic Hypertension.</b>		
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) _____		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>September 28 1972</b> to <b>September 28 1972</b> that (I) (we) last saw the deceased alive on <b>September 28 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Robert Kneopnick, M.D.</b>		23B. DATE SIGNED <b>9/28/72</b>		23C. PHYSICIAN'S NAME (Type)
23D. ADDRESS <b>9008 Meadowheights Road, Maryland</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		
24B. DATE <b>10-2-72</b>		24C. NAME of CEMETERY or CREMATORY <b>Cedar Hill Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 2 1972</b>		25B. NAME OF REGISTRAR <b>John H. H. H.</b>		25C. FUNERAL DIRECTOR <b>Armacost Funeral Chapel-4600 Liberty Hghts</b>



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

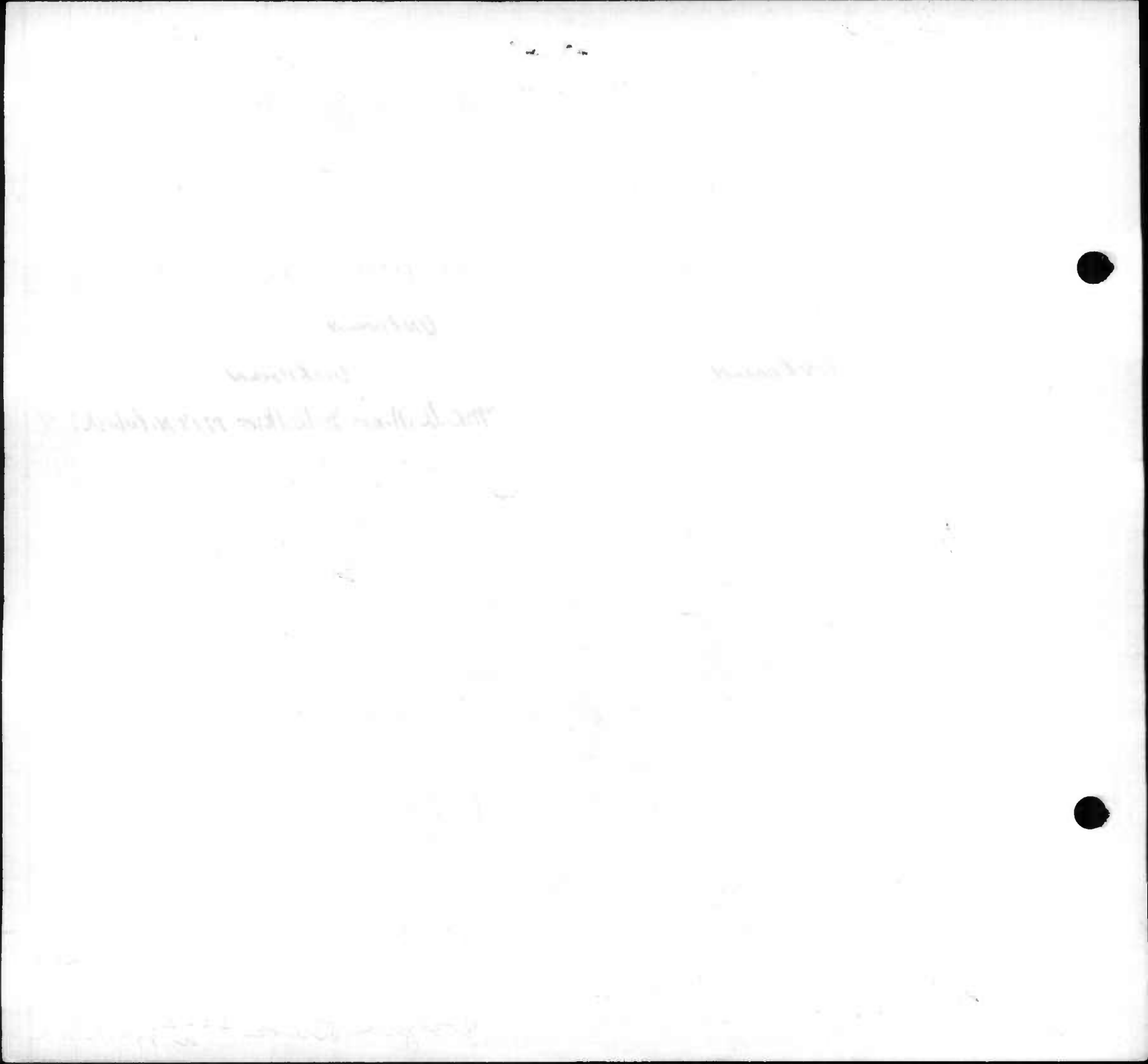
BALTIMORE CITY HEALTH DEPARTMENT										
72 09388					72 09388					
BIRTH NO.					REG. NO.					
1. NAME OF DECEASED (Type or Print) <b>MARY J. HINTON</b>					2. DATE AND HOUR OF DEATH <b>10. 1. 72 8.57 A.M.</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>U.S.A.</b>					
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSPITAL</b>					C. CITY OR TOWN <b>BALTIMORE</b>					
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
E. STREET AND NUMBER <b>2708 MATHEWS ST.</b>										
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-30-23</b>	9. AGE (In years last birthday) <b>48</b>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNABLE</b>			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>WILBUR WELLS</b>					14. MOTHER'S MAIDEN NAME <b>SWAN</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>220-22-9496</b>		17. INFORMANT ADDRESS <b>(DAUGHTER) Joan Hinton</b>					
18. <b>712.3 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>METABOLIC DISTURBANCE</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>ADRENAL FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>RHEUMATOID ARTHRITIS</b>					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b>										
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).										
19A. DATE OF OPERATION <b>0</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>9.30</b> 19 <b>72</b> to <b>10.1</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>10.1</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <b>[Signature]</b>					23B. DATE SIGNED <b>10.1.72</b>					
23C. PHYSICIAN'S NAME (Type) <b>CARLOS H. SANTILLAN, M.D.</b>					23D. ADDRESS <b>THE UNION MEMORIAL HOSP., BALTO MD. 21218</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>10/5/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 8 1972</b>			25B. NAME OF REGISTRAR <b>[Signature]</b>			25C. FUNERAL DIRECTOR <b>WME MARCH</b>			ADDRESS <b>928 E North Ave</b>	

75 APR 1957

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 09389</b>	
J-520 <b>CERTIFICATE OF DEATH</b>					
BIRTH NO. <b>72 09389</b>		1. NAME OF DECEASED (Type or Print) <b>JONES, HESTER M.</b>			
2. DATE AND HOUR OF DEATH <b>9/21/72 10:10 a.m.</b>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>1503</b>		5. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>LUTHERAN HOSPITAL OF MARYLAND</b>			
6. CITY OR TOWN <b>BALTIMORE</b>		7. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
8. STREET AND NUMBER <b>1718 N. PULASKI ST</b>					
9. SEX <b>F</b>	10. RACE <b>N</b>	11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	12. DATE OF BIRTH <b>5/9/1898</b>	13. AGE (In years last birthday) <b>74</b>	14. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		16. KIND OF BUSINESS OR INDUSTRY		17. BIRTHPLACE (State or foreign country) <b>UNKNOWN</b>	
18. FATHER'S NAME <b>UNKNOWN</b>		19. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		20. CITIZEN OF WHAT COUNTRY?	
21. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		22. SOCIAL SECURITY NO.		23. INFORMANT ADDRESS <b>Mr. William M. Wilkins 1718 N. Pulaski St</b>	
18. <b>1</b> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>(A) IMMEDIATE CAUSE <b>RENAL FAILURE - DUE TO INFECTION, POST-OP HYPOTENSION.</b></p> <p>(B) <b>PNEUMONIA - HYPOSTATIC.</b></p> <p>(C) _____</p> </div> <div style="width: 50%;"> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8/21/72</b> 19__ to <b>9/21/72</b> 19__ that (I) (we) last saw the deceased alive on <b>9/21/72</b> 19__ and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>B. Khosh</b>		M.D. DEGREE <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>9/21/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>B. Khosh</b>		23D. ADDRESS <b>Luth. Hosp. of Md. 730 Ashburton St. Md</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>9-26-72</b>		24C. NAME of CEMETERY or CREMATORY <b>Baltimore Cemetery</b>	
24D. LOCATION <b>Baltimore</b>		(City, town, or county)		(State) <b>Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 2 1972</b>		25B. NAME OF REGISTRAR <b>Frederick W. Hinton</b>		25C. FUNERAL DIRECTOR <b>George E. Ruse 2222 W. Mount Airy</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09390		72 09390	
BIRTH NO. M-320				72 09390		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
MATTHEWS, WILLIAM H				SEPTEMBER 29, 1972 8:XXA M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
40 ST. AGNES HOSPITAL				MARYLAND BALTIMORE			
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				BALTIMORE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER			
				409 OELLA AVE 21228			
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
MALE		NEGRO		WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		01/26/24	
						48	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
CONSTRUCTION						MARYLAND	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
GEORGE MATTHEWS				ANNIE BROWN MATTHEWS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
YES W W 2				217-20-7300		ST. AGNES HOSPITAL RECORDS	
18. 571-01				CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)				Bronchopneumonia			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Chronic alcoholism			
				(C) Fatty liver			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				YES			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 28 1972 to SEPTEMBER 29 1972, that (I) (we) last saw the deceased alive on SEPTEMBER 29 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
E. Bengen						9/29/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
EITATSU HENZAN				BALTIMORE, MD 21229			
				ST. AGNES HOSPITAL; CATON & WILKENS AVES			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		10/5/72		Mt Auburn Cemetery		Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
OCT 3 1972		A. Wilkins		H. Halstead		1226 W. North Ave	





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Edith Richardson</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>9 28 72 7:20 P. M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>719 N. Carrollton Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>9 28 72 7:20 P. M.</b>	
6. SEX <b>Female</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>1896</b>		10. AGE (In years last birthday) <b>76</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF <b>WHAT COUNTRY?</b>	
13. FATHER'S NAME <b>Joseph Wynn</b>		14. MOTHER'S MAIDEN NAME <b>Margaret</b>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		18. SOCIAL SECURITY NO.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>No</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I hold an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>W P Mulloy</b> M.D. EXAMINER'S NAME (Type) <b>William P. Mulloy, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>9-29-72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/4/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>National Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 3 1972</b>		25B. NAME OF REGISTRAR <b>Adolphus Halstead</b>	
25C. FUNERAL DIRECTOR <b>Adolphus Halstead</b>		ADDRESS <b>1206 W. North Ave</b>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>1-520 72 09392 BALTIMORE CITY HEALTH DEPARTMENT</p> <p><b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. 72 09392</p> <p><b>STATE OF MARYLAND-DHME</b></p>	
<p>BIRTH NO.</p> <p>1. NAME OF DECEASED (Type or Print) <u>Wallace Young</u></p>		<p>2. DATE AND HOUR OF DEATH <u>October 1, 1972</u> 3:25 <u>A</u> M.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Lutheran Hospital</u></p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2716</u></p>	
<p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Lutheran Hospital</u></p>		<p>C. CITY OR TOWN <u>Baltimore</u></p>	<p>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>
<p>5. SEX <u>Male</u></p>	<p>6. RACE <u>Negro</u></p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>4-9-17</u></p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>	<p>9. AGE (In years last birthday) <u>58</u></p>
<p>11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u></p>		<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>	
<p>13. FATHER'S NAME <u>William Young</u></p>		<p>14. MOTHER'S MAIDEN NAME <u>Holliday</u></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u></p>		<p>16. SOCIAL SECURITY NO. <u>214-01-0983</u></p>	<p>17. INFORMANT <u>Jerline Young, 3030 Virginia Ave.</u></p>
<p>18. <u>153181</u> CAUSE OF DEATH</p>			
<p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Respiratory Failure</u></p>		<p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</p>	
<p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <u>Carcinoma of the colon</u></p>		<p>(B) <u>Carcinoma of the colon</u> DUE TO, OR AS A CONSEQUENCE OF:</p>	
<p>(C)</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION <u>10-1-72</u></p>	<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	<p>20A. AUTOPSY? (Yes or No) <u>NO</u></p>	<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>	<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>	<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <u>8-16-72</u> to <u>10-1-72</u> that (I) (we) lost saw the deceased alive on <u>10-1-72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <u>Louderes M. Victoria</u> M.D. DEGREE</p>		<p>23B. DATE SIGNED <u>10-1-72</u></p>	<p>Attending <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> Intern <input checked="" type="checkbox"/></p>
<p>23C. PHYSICIAN'S NAME (Type) <u>Louderes M. Victoria</u> M.D. DEGREE</p>		<p>23D. ADDRESS <u>Lutheran Hosp. of Maryland</u></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u></p>	<p>24B. DATE <u>Oct. 4, 72</u></p>	<p>24C. NAME of CEMETERY or CREMATORY <u>Woodlawn Cemetery</u></p>	<p>24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u></p>
<p>25A. DATE REC'D BY HEALTH DEPT. <u>OCT 3 1972</u></p>		<p>25B. NAME OF FUNERAL DIRECTOR <u>Kenneth Law</u></p>	
<p>25C. ADDRESS <u>4611 Park Heights Ave.</u></p>		<p>25D. ADDRESS</p>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09393	
7-520 72 09393				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
ASHTON FINK		9/24/72 1145 P M.		FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL 42 ICU	
5. SEX MASC		6. RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 05/16/02	
RETIRED		NOT KNOWN		9. AGE (In years last birthday) 70	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
NOT KNOWN		U.S.A.		NOT KNOWN	
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
NOT KNOWN		NOT KNOWN		NOT KNOWN	
17. INFORMANT		18. CAUSE OF DEATH		19. MEDICAL CERTIFICATION	
HOSP. RECORDS		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CA of Phorinx		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
		(B) DUE TO, OR AS A CONSEQUENCE OF:		19A. DATE OF OPERATION	
		(C) DUE TO, OR AS A CONSEQUENCE OF:		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
				20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Specify medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/21/72 19 to 9/24/72 19		that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE ROBERTO FRIDMAN	
23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
		ROBERTO FRIDMAN		SINAI HOSPITAL BALTO.	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
9-28-72		9-28-72		U.S. M. ANNUARY BARR BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
OCT 3 1972		Sidney Johnston		RAYMOND V. CURRAN	

5/14/72 - Adm.

Prev. Address also N. H.

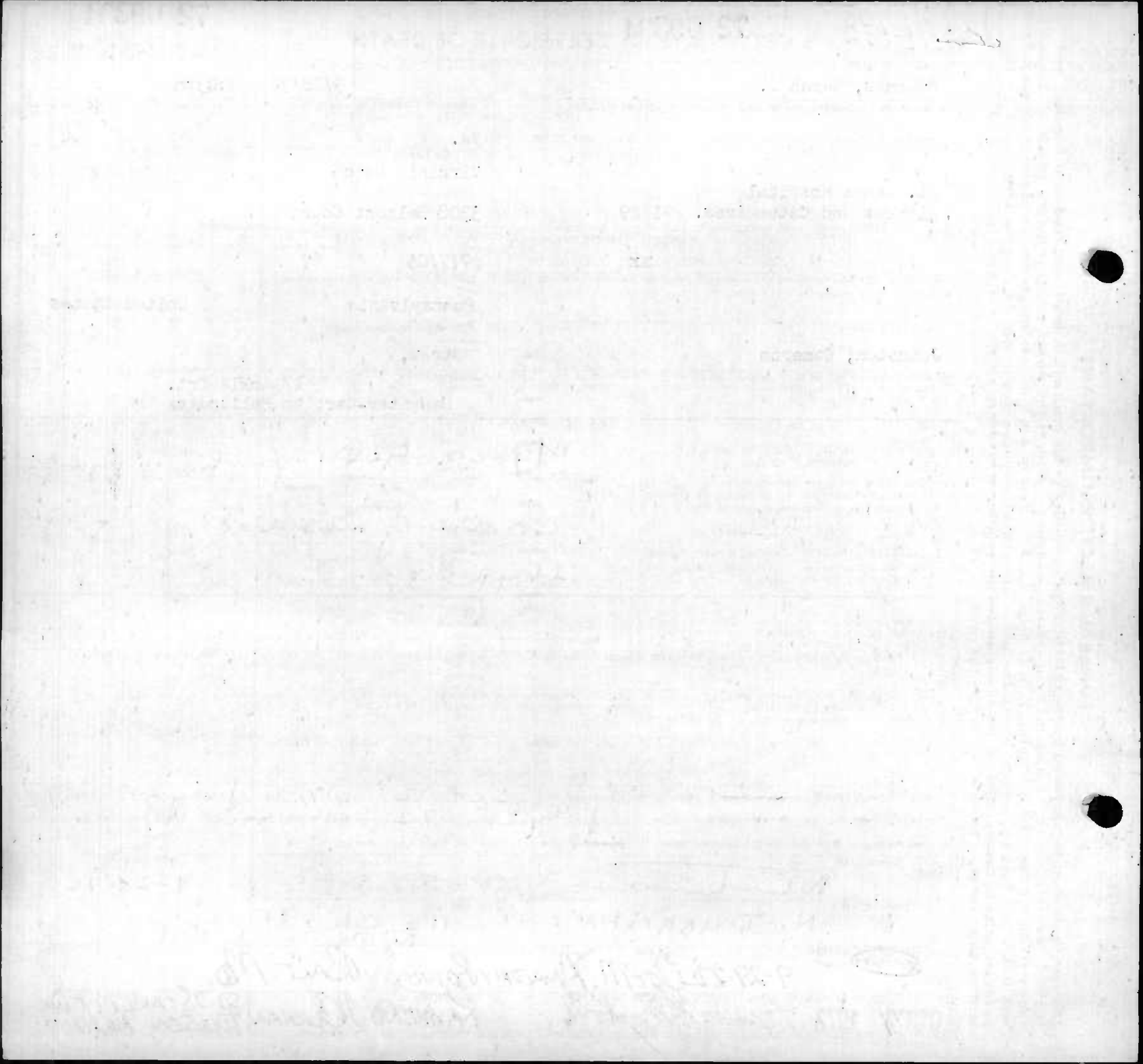
coded to 4613 Park Hgts.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>72 09394</span> <span>ALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		<div style="display: flex; justify-content: space-between;"> <span>72 09394</span> <span>REG. NO.</span> </div> <h3 style="text-align: center;">STATE OF MARYLAND-DEMO</h3>	
BIRTH NO. <span style="font-size: 1.5em;">M-252</span>		1. NAME OF DECEASED (Type or Print) <b>McComas, Sarah J.</b>	
2. DATE AND HOUR OF DEATH <b>9/28/72 3:03pm</b>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>St. Agnes Hospital Wilkins and Caton Aves. 21229</b>	
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Va.</b> B. COUNTY <b>V43</b>		5. SEX <b>F</b> 6. RACE <b>W</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>7/7/05</b> 9. AGE (In years last birthday) <b>67</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>Johnston, Cameron</b>		14. MOTHER'S MAIDEN NAME <b>Straw,</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>17 Arkla Crt. Daughter-Carolyn Mellendick</b>		ADDRESS	
18. <b>410.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Myocardial infarction in minutes</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Coronary disease.</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Hypertension</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>Oct 12 1971</b> to <b>July 25 1972</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>July 25 1972</b> and that in (my) ( <del>your</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>was</del> ) ( <del>did</del> ) (did not) view the body after death.			
23A. SIGNATURE <b>N. Turkman</b>		23B. DATE SIGNED <b>9-28-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>N. TURKMAN</b>		23D. ADDRESS <b>112 Charley Drive, Baltimore, Md.</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <b>9-29-72</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>COFM, Anatomy Board</b>		24D. LOCATION (City, town, or county) (State) <b>BALT. MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 3 1972</b>		25B. NAME OF REGISTRAR <b>Raymond J. Curran</b>	
25C. FUNERAL DIRECTOR <b>RAYMOND J. CURRAN</b>		ADDRESS <b>8725 SCARLETT DR, TOWSON, MD 21204</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1-623 72 09395		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		72 09395 REG. NO. <b>STATE OF MARYLAND-DEME</b>	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Elizabeth Christle</i>		2. DATE AND HOUR OF DEATH <i>10-1-72 @ 6 PM</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If NOT in hospital or institution, give street address or location) <i>102 N. PACA ST BALTIMORE MD</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>361</i>		M.	
5. SEX <i>F</i>		6. RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>UNKNOWN</i>		9. AGE (In years last birthday) <i>ABOUT 85</i>		10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>UNKNOWN</i>		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <i>UNKNOWN</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13. FATHER'S NAME <i>UNKNOWN</i>		14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>UNKNOWN</i>		17. INFORMANT <i>CENTURY NURSING HOME</i>	
18. <i>412.41</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.		CAUSE OF DEATH <i>Cardio-Respiratory Failure</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Arteriosclerotic CVA</i> (B) <i>Gen + Cor Pulm Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Senility</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>William D Appleford</i>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <i>William D Appleford MD</i>	
23D. ADDRESS <i>6615 Neuters Farm Rd</i>		24A. BURIAL CREMATION, REMOVAL (Specify)			
24B. DATE <i>10/6/72</i>		24C. NAME OF CEMETERY or CREMATORY <i>Louisa Park Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>BALTIMORE MD</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 3 1972</i>		25B. NAME OF REGISTRAR <i>Anthony [Signature]</i>		25C. FUNERAL DIRECTOR <i>R. CURRAN</i>	
25D. ADDRESS <i>817 SCARLETON TOWSON, MD 21204</i>					

7/9/68 - Adm.  
337 S. Herring Ct, (31)

10/5/72 - Correction form from funeral director.

*abc*

72 09396

STATE OF MARYLAND-DMH  
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 09396

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Willie Miller		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 9 16 72 6:55 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 9 16 72 6:55 P.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH UNKNOWN		10. AGE (In years last birthday) 36	
11. BIRTHPLACE (State or foreign country) UNKNOWN		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME UNKNOWN		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN	
15. MOTHER'S MAIDEN NAME UNKNOWN		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) UNKNOWN	
17. SOCIAL SECURITY NO. UNKNOWN		18. INFORMANT BALT. CITY MED. EXAMINER	
19. CAUSE OF DEATH E9671X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) house	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 725 George Street - rear		22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 9 16 72 6:00 P.m.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? thrown from 4th floor balcony	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>W P Mulloy</i> M.D. EXAMINER'S NAME (Type) William P. Mulloy, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9-17-72			
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE 10-2-72	
24C. NAME OF CEMETERY OR CREMATORY Norm Anatomy Board		24D. LOCATION (City, town, or county) (State) BALT, MD	
25A. DATE REC'D BY HEALTH DEPT. OCT 3 1972		25B. NAME OF REGISTRAR Sidney H. [illegible]	
25C. FUNERAL DIRECTOR Raymond C. Curran		25D. ADDRESS 817 SCARLETT DR DOWSON, MD 21224	

THE UNIVERSITY OF CHICAGO

THE UNIVERSITY OF CHICAGO  
LIBRARY  
540 EAST 57TH STREET  
CHICAGO, ILL. 60637

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CHICAGO, ILL. 60637



E-420

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 09397

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Charles Ellis</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>9 23 72</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 326 E. 20½ Street</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>9 23 72 1:15 a.</b> M.	
6. SEX <b>male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>UNKNOWN</b>		10. AGE (In years last birthday) <b>75</b>	
11. BIRTHPLACE (State or foreign country) <b>UNKNOWN</b>		12. CITIZEN OF <b>RES. U.S.</b>	
13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNKNOWN</b>		16. KIND OF BUSINESS OR INDUSTRY <b>UNKNOWN</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b>		18. SOCIAL SECURITY NO. <b>UNKNOWN</b>	
19. 412.4 + 150X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		20. CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b>	
21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Carcinoma of esophagus</b>		22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Carcinoma of esophagus</b>	
23A. DATE OF OPERATION <b>0</b>		23B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
24A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		24B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
24C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		24D. HOW DID INJURY OCCUR?	
24E. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Min.)		24F. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
25. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Marvin S. Platt</b> EXAMINER'S NAME (Type)		DATE SIGNED <b>9/23/72</b>	
26A. BURIAL CREMATION, REMOVAL (Specify)		26B. DATE <b>10-2-72</b>	
26C. NAME OF CEMETERY or CREMATORY <b>U of M Anatomy Bldg</b>		26D. LOCATION (City, town, or county) (State) <b>Balt MD</b>	
26E. DATE REC'D BY HEALTH DEPT. <b>OCT 3 1972</b>		26F. NAME OF REGISTRAR <b>Raymond Curran</b>	
26G. FUNERAL DIRECTOR <b>Raymond Curran</b>		26H. ADDRESS <b>817 SCARLETT DR BALTIMORE MD 21204</b>	



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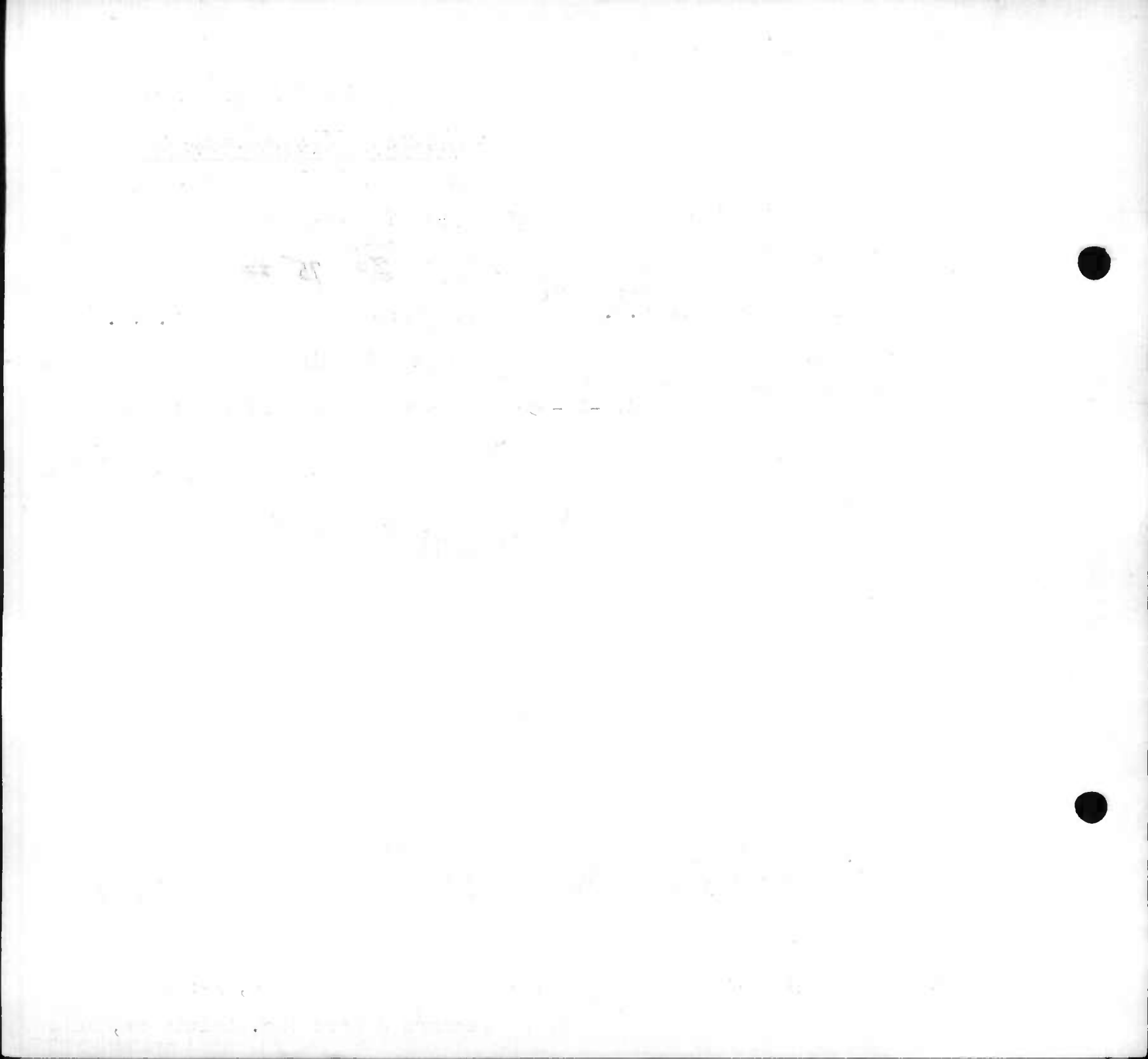
75-10000

75-10000

75-10000

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

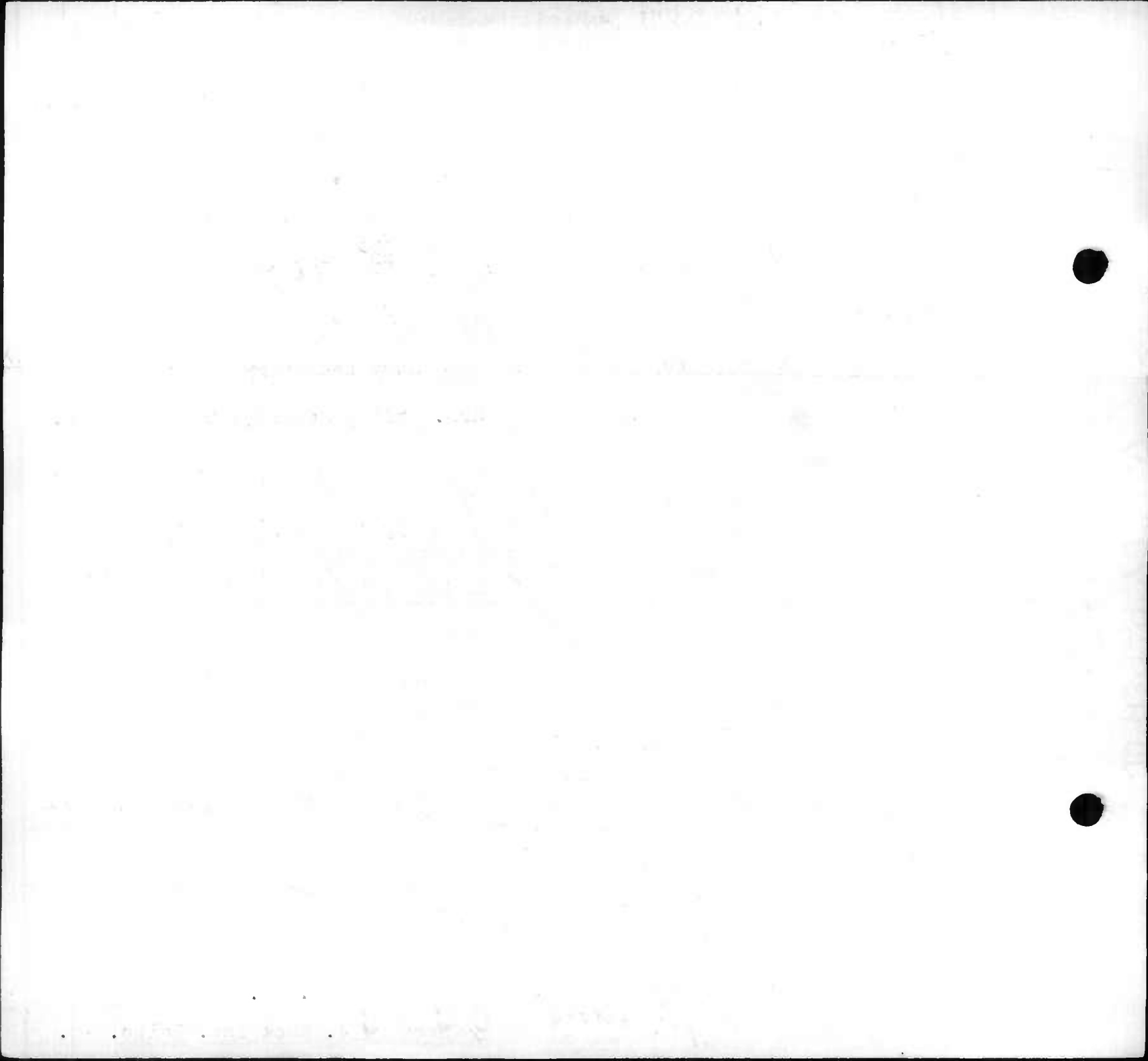
VS 150-REV. 1/1/68



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

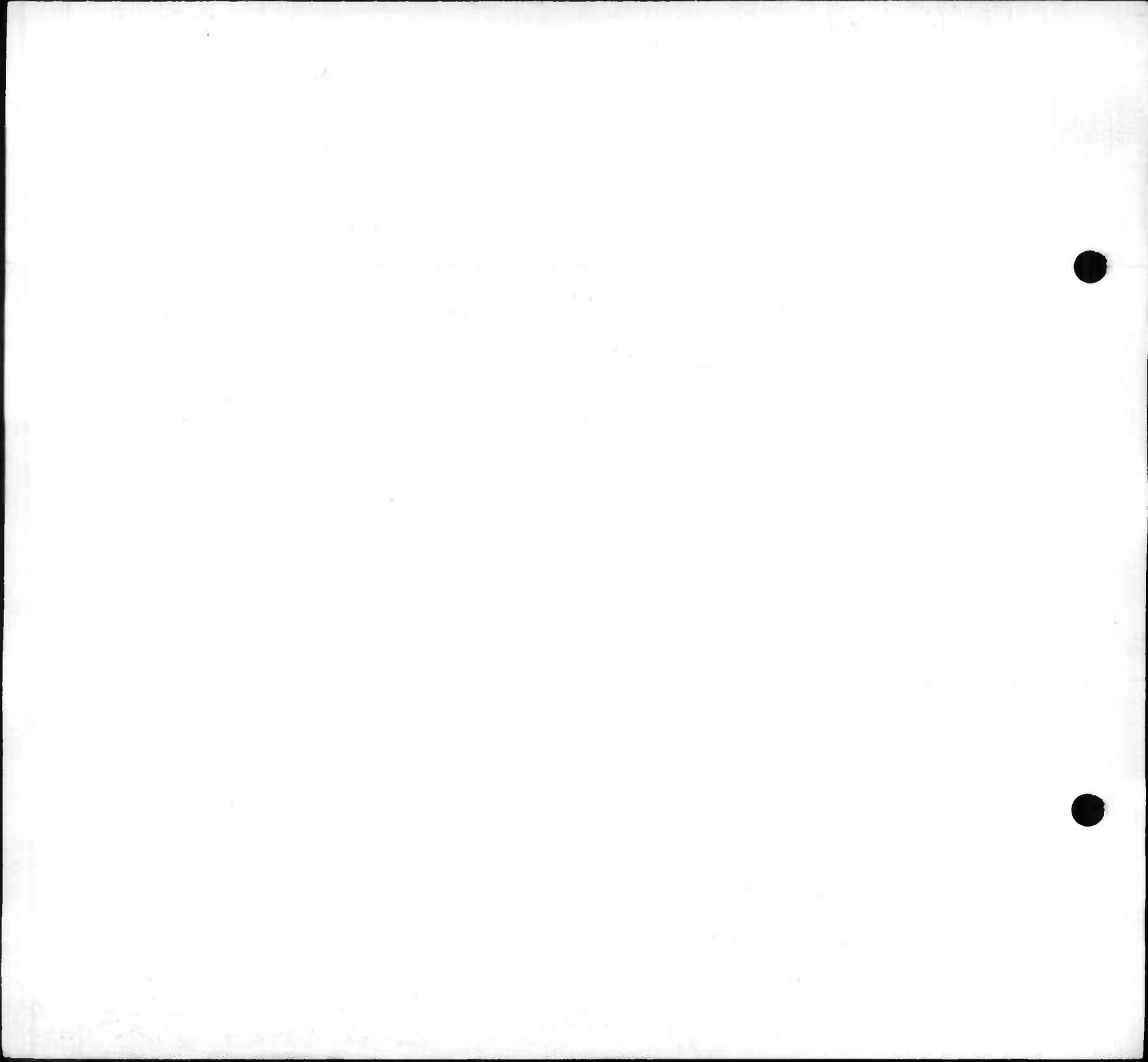
72 09399		BALTIMORE CITY HEALTH DEPARTMENT		72 09399	
E-400		CERTIFICATE OF DEATH		STATE OF MARYLAND-DHME	
1. NAME OF DECEASED (Type or Print) <u>MARY A. ELY</u>		2. DATE AND HOUR OF DEATH <u>9-29-72</u> <u>11:30 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Lutheran Hospital of Maryland</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1509</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>4014 Fairview Avenue</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-9-78</u>	9. AGE (In years last birthday) <u>76</u> years	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>Joseph McCauley</u>		14. MOTHER'S MAIDEN NAME <u>Mary Dougherty</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT ADDRESS <u>Mrs. Philip Meyers 416 Donegal Dr.</u>	
18. <u>560.31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Aspiration pneumonia</u> (B) <u>Pulmonary Lobular Abscess</u> (C) <u>Focal Infection</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 Weeks</u> <u>3 Days</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Breast</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <u>9-26-72</u> to <u>9-29-72</u> that (I) (we) last saw the deceased alive on <u>2-20-72</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>9-29-72</u>		23C. PHYSICIAN'S NAME (Type) <u>M. A. ANWAR MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/3/72</u>		24C. NAME of CEMETERY or CREMATORY <u>New Cathedral</u>	
24D. LOCATION <u>Balto. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 3 1972</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>	
25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc.</u>		ADDRESS <u>Balto. Md.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-650		72 09400		BALTIMORE CITY HEALTH DEPARTMENT		72 09400	
BIRTH NO.		CERTIFICATE OF DEATH				REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH				STATE OF MARYLAND-DEATH	
MR. HENRY E. BROWN		OCT. 1 1972 6:15 A.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE B. COUNTY		C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		1108 S. PACA STREET MD.		BALTO.			
Bon Secours Hospital		E. STREET AND NUMBER		1108 S. PACA STREET 2101			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.	
MALE	W			5/12/03	69 yrs.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
RETIRED LABORER		STEEL WORKER		MARYLAND		U. S.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
WARREN BROWN		MINNIE TAYLOR		No.		216-05-8730	
17. INFORMANT		ADDRESS		18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
CHART AND FAMILY				437.91			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		C. V. A.			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last		(B) Cerebral arteriosclerosis			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last		(C)		(D)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Approx.)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Approx.)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from Sep 26 19 72 to Oct 1 19 72 that (I) (we) last saw the deceased alive on Oct 1 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
C. J. Ahn		OCT 1 1972		CHOON JA Ahn		Bon Secours hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		10/4/72		Cedar Hill Ceme.		Annapolis, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
OCT 3 1972		John J. Conner		John J. Conner		940 Hollins St. Balt. 21223	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>252 06P 09401</b>	
S-525 72 09401		CERTIFICATE OF DEATH	
BIRTH NO.		STATE OF MARYLAND - DEME	
1. NAME OF DECEASED (Type or Print) <b>SENSENIG, LEWIS B.</b>		2. DATE AND HOUR OF DEATH <b>9/30/72 10 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>PA</b> B. COUNTY <b>—</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>USPHS HOSPITAL BALTIMORE, MD</b>		C. CITY OR TOWN <b>MANHEIM</b> D. INSIDE CITY LIMITS? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <b>RD # 4</b>	
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/10/54</b>
9. AGE (In years last birthday) <b>18</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STUDENT</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>PA Ephrata, Penn.</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>AMOS SENSENIG</b>		14. MOTHER'S MAIDEN NAME <b>ALTA BURKHOLDER</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKN</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>RD 4</b> ADDRESS <b>Amos B. Sensenig Manheim, Pennsylvania</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>204.0</b> <b>ACUTE LYMPHOCYTIC LEUKEMIA</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>YRS</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>GI. HEMORRAGE &amp; PNEUMONIA</b>		<b>DAYS</b>	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>7/17</b> 19 <b>72</b> to <b>9/30</b> 19 <b>72</b> that (I) (we) lost saw the deceased alive on <b>9/30</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Vija L. Bauer, M.D.</b>		23B. DATE SIGNED <b>10/1/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Vija L. Bauer, M.D.</b>		23D. ADDRESS <b>USPHS HOSPITAL, BALTIMORE MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-3-1972</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Clearview Mennonite</b>		24D. LOCATION (City, town, or county) (State) <b>Lancaster County, Pennsylvania</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 3 1972</b>		25B. NAME OF REGISTRAR <b>Anthony Washington</b>	
25C. FUNERAL DIRECTOR <b>Lilly &amp; Zeidler Inc.</b>		ADDRESS <b>1901-07 Eastern Ave. Baltimore, Maryland</b>	

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James H. Bennett, Nashville, Tennessee

James H. Bennett, Nashville, Tennessee

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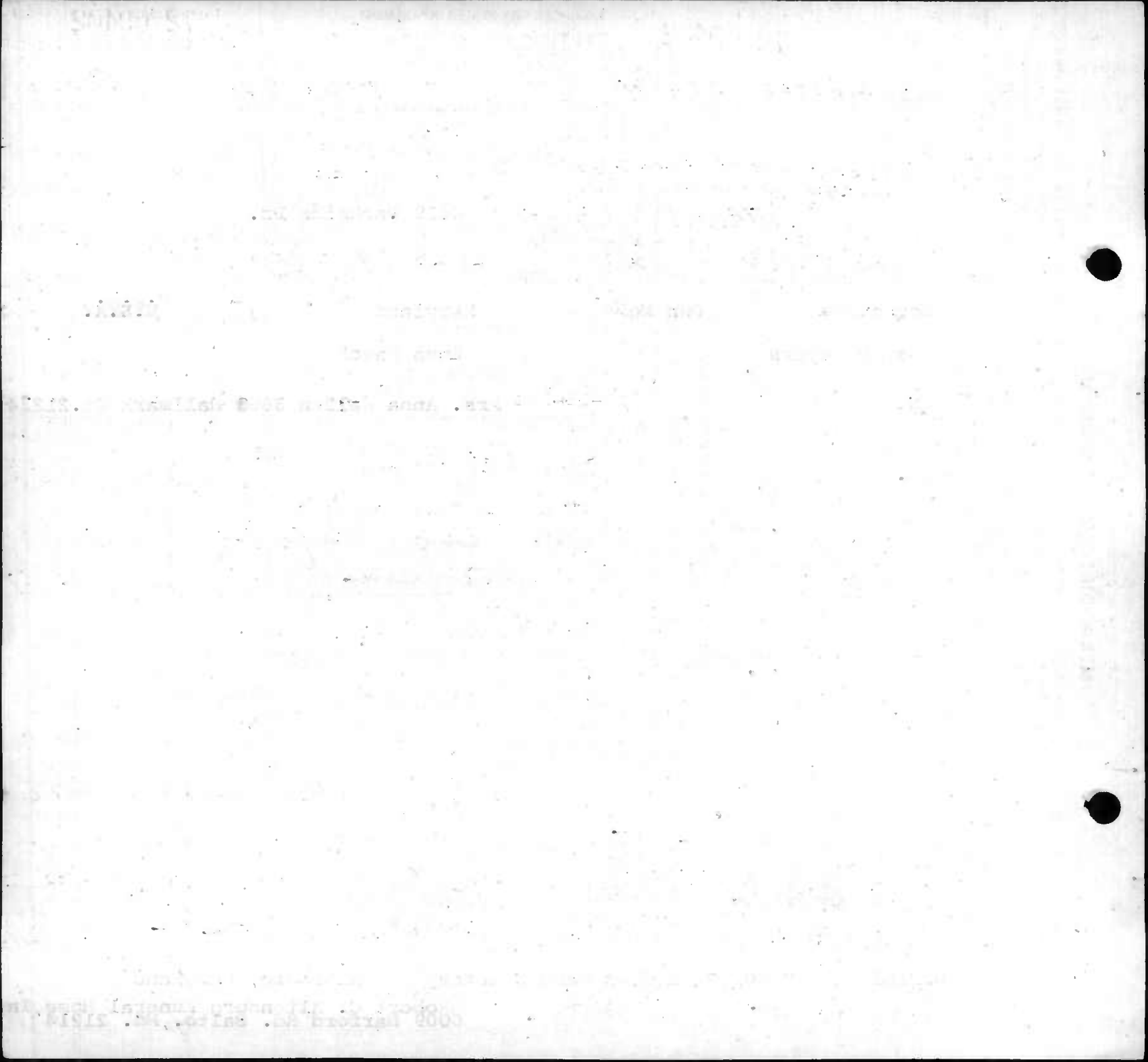
10-1-1972

10-1-1972

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>5-365 72 09402</b></p> <p><b>BIRTH NO.</b></p>		<p><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p><b>CERTIFICATE OF DEATH</b></p>		<p><b>REG. NO. 72 09402</b></p> <p><b>STATE OF MARYLAND - DHMH</b></p>	
<p><b>1. NAME OF DECEASED</b> (Type or Print) <b>MRS. MYRTLE STRAN</b></p>			<p><b>2. DATE AND HOUR OF DEATH</b> <b>9-27-72 1:51 P.M.</b></p>		
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p> <p><b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>90 HAMILTON NURSING CENTER 6040 HARFORD RD. HAMILTON 4214</b></p>			<p><b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) <b>A. STATE</b> <b>MD</b> <b>B. COUNTY</b> <b>2731</b></p> <p><b>C. CITY OR TOWN</b> <b>BALTIMORE</b> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p><b>E. STREET AND NUMBER</b> <b>4019 Parkside Dr.</b></p>		
<p><b>5. SEX</b> <b>FEMALE</b></p>	<p><b>6. RACE</b> <b>WHITE</b></p>	<p><b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p>	<p><b>8. DATE OF BIRTH</b> <b>6-23-99</b></p>	<p><b>9. AGE</b> (In years last birthday) <b>73</b></p>	<p><b>If Under 1 Yr.</b> Months: Days: <b>If Under 24 Hrs.</b> Hours: Min.</p>
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b></p>		<p><b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>Own Home</b></p>		<p><b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b></p>	
<p><b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b></p>			<p><b>13. FATHER'S NAME</b> <b>Harry Meyers</b></p>		
<p><b>14. MOTHER'S MAIDEN NAME</b> <b>Emma Dasch</b></p>			<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b></p>		
<p><b>16. SOCIAL SECURITY NO.</b> <b>217-36-3068</b></p>			<p><b>17. INFORMANT</b> <b>Mrs. Anna Wallen 3608 Hallmark Ct. 21234</b></p>		
<p><b>18. 433.91</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>1. Cerebral Thrombosis</b> <b>2. Myoplegia Cerebralis</b> <b>3. AS - Ch. failure</b> <b>4. Status epilepticus</b></p>			<p><b>CAUSE OF DEATH</b> <b>1. Cerebral Thrombosis</b> <b>2. Myoplegia Cerebralis</b> <b>3. AS - Ch. failure</b> <b>4. Status epilepticus</b></p>		
<p><b>19. DATE OF OPERATION</b> <b>0</b></p>			<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>		
<p><b>20A. AUTOPSY?</b> (Yes or No)</p>			<p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>		
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)</p>			<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		
<p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>			<p><b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)</p>		
<p><b>21E. INJURY OCCURRED</b> <b>While At Work</b> <input type="checkbox"/> <b>Not While At Work</b> <input type="checkbox"/></p>			<p><b>21F. HOW DID INJURY OCCUR?</b></p>		
<p><b>22. I certify that (I) (this hospital) attended the deceased from 9/19 1972 to 9/27 1972 that (I) (we) last saw the deceased alive on 9/25 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b></p>					
<p><b>23A. SIGNATURE</b> <b>Donald W. Miltzer</b></p>			<p><b>23B. DATE SIGNED</b> <b>9/27/72</b></p>		
<p><b>23C. PHYSICIAN'S NAME (Type)</b> <b>DONALD W. MILTZER</b></p>			<p><b>23D. ADDRESS</b> <b>3009 EVERGREEN AVE BALTIMORE</b></p>		
<p><b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>Burial</b></p>		<p><b>24B. DATE</b> <b>9/30/72</b></p>		<p><b>24C. NAME OF CEMETERY OR CREMATORY</b> <b>Loudon Park Cemetery</b></p>	
<p><b>24D. LOCATION</b> (City, town, or county) (State) <b>Baltimore, Maryland</b></p>		<p><b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>OCT 3 1972</b></p>			
<p><b>25B. NAME OF REGISTRAR</b> <b>Disney</b></p>		<p><b>25C. FUNERAL DIRECTOR</b> <b>Robert C. Altenburg Funeral Home, Inc.</b></p>			
<p><b>25D. ADDRESS</b> <b>6009 Harford Rd. Balto., Md. 21214</b></p>		<p><b>VS 150-REV. 1/1/68</b></p>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72 69403 STATE OF MARYLAND - DEATH	
BIRTH NO. L-520 72 9403					
1. NAME OF DECEASED (Type or Print) LYONS, MR. JOHN R.		2. DATE AND HOUR OF DEATH 9/29/72 1 5 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH HOME AND HOSPITAL 100 N. BROADWAY BALTIMORE MARYLAND 21231		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER BOX 204 GOLUPSKI ROAD 21221			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/21/18	9. AGE (In years last birthday) 54	If Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COMPUTER PROGRAMMER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? AMERICA
13. FATHER'S NAME SAMUEL LYONS		14. MOTHER'S MAIDEN NAME Carrie Weckesser CARRIE WECKESSER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-14-4224		17. INFORMANT ADDRESS Emory Lyons - 4 Branch St. 21221	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/25/1972 to 9/29/1972 that (I) (we) last saw the deceased alive on 9/28/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE R. Swaminathan MD DEGREE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/29/72	
23C. PHYSICIAN'S NAME (Type) D.V. SADARANANDA MD DEGREE		23D. ADDRESS 100 N. BROADWAY			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 10/2/72	24C. NAME OF CEMETERY or CREMATORY Mt. Olivet Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. OCT 3 1972		25B. NAME OF REGISTRAR Sidney M. [Signature]		25C. FUNERAL DIRECTOR Robert C. Altenburg Funeral Home, Inc. 6009 Harford Rd. - Balto., Md. 21214	

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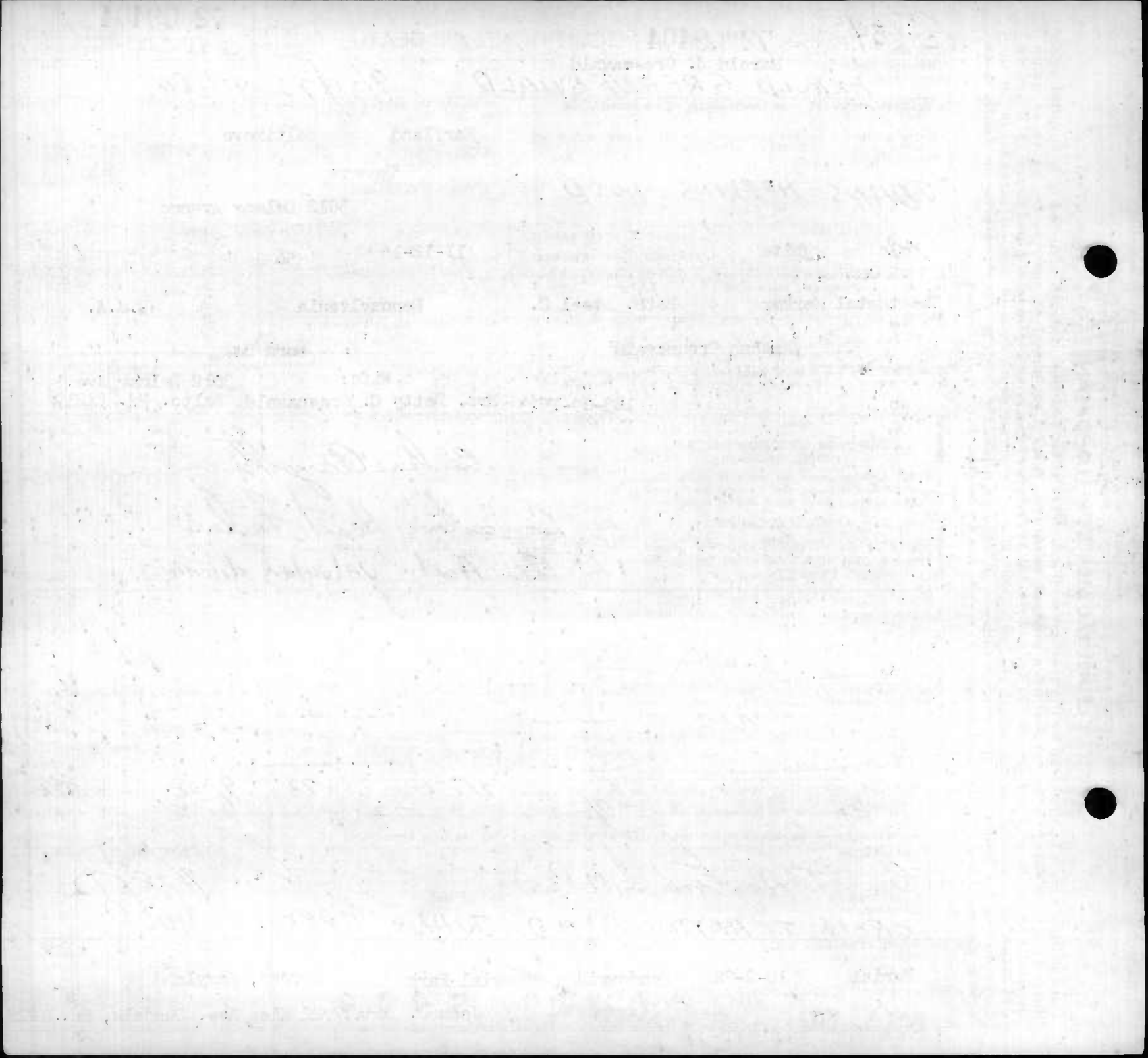


**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

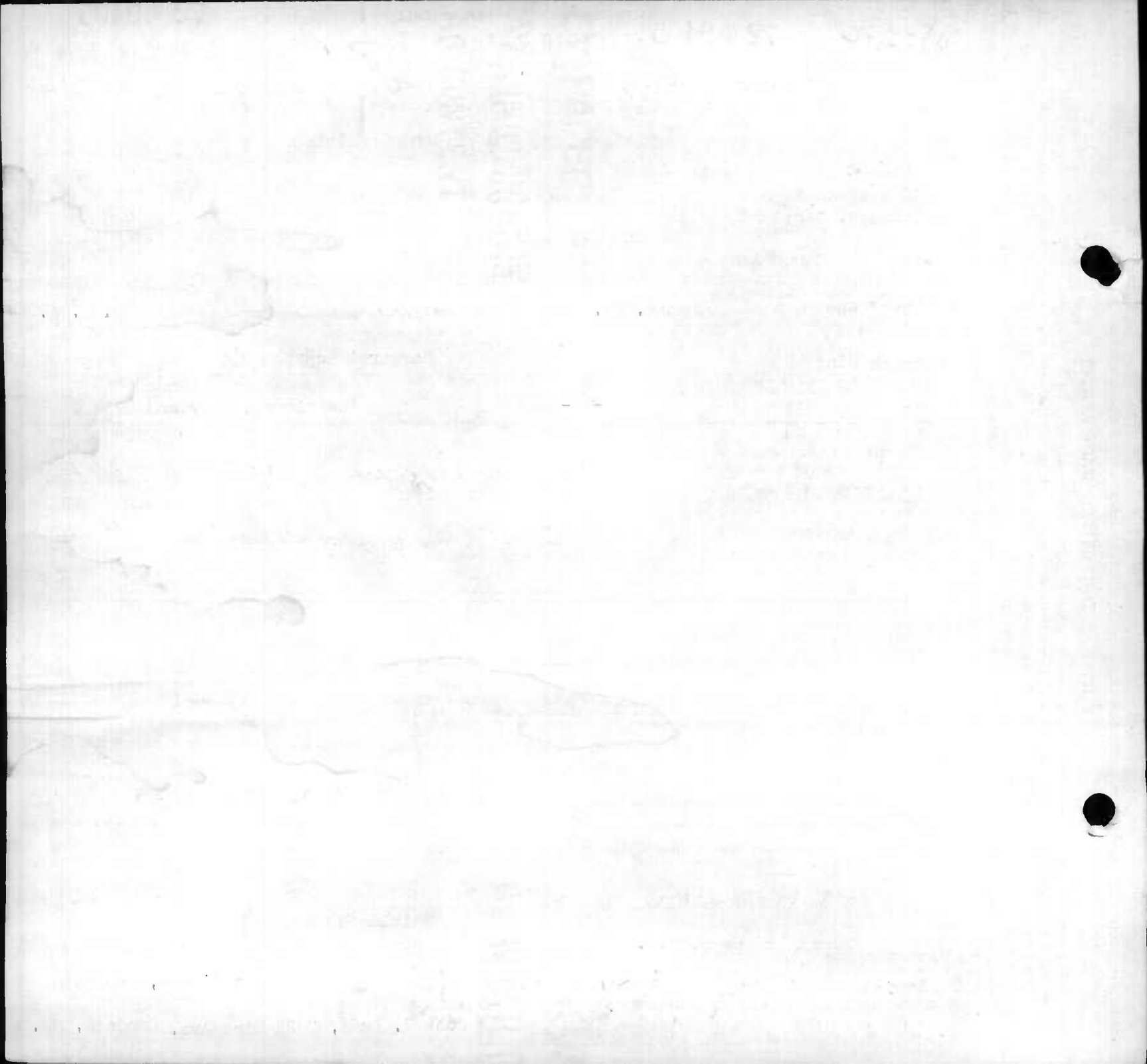
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09404	
G-654 72 09404				CERTIFICATE OF DEATH	
BIRTH NO.		STATE OF MARYLAND - DEPT			
1. NAME OF DECEASED (Type or Print) <b>HAROLD GREENAWALD</b>		2. DATE AND HOUR OF DEATH <b>9/28/72 4:30 PM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>JOHNS HOPKINS HOSP</b>		C. CITY OR TOWN <b>Edgemere</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <b>3012 Delmar Avenue</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-12-15</b>	9. AGE (In years last birthday) <b>56</b>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sheetmetal Worker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel C.</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
13. FATHER'S NAME <b>Nathan Greenawald</b>		14. MOTHER'S MAIDEN NAME <b>Nora Hoy</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>183-09-1573</b>		17. INFORMANT <b>Wife:</b> <b>Mrs. Betty C. Greenawald Balto. Md. 21219</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cardiac Arrhythmia</b> (B) <b>Congestive Heart Failure</b> (C) <b>Aortic Valvular disease</b>			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/1/72</b> 19 <b>72</b> to <b>9/28</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>9/28</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Craig T. Haytmanek, M.D.</b>				23B. DATE SIGNED <b>9/28/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>CRAIG T. HAYTMANEK, M.D.</b>				23D. ADDRESS <b>JOHNS HOPKINS HOSP</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-2-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Meadowridge Memorial Park</b>	
24D. LOCATION <b>Dorsey, Maryland</b>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 3 1972</b>		25B. NAME OF REGISTRAR <b>Sidney [Signature]</b>		25C. FUNERAL DIRECTOR <b>John J. Duda 7922 Wise Ave. Dundalk, Md. 21222</b>	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
K-520		72 09405		72 09405	
1. NAME OF DECEASED (Type or Print)		Albert G. King		2. DATE AND HOUR OF DEATH 9/27/72 11 <sup>10</sup> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE Maryland	
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		B. COUNTY Baltimore		C. CITY OR TOWN Dundalk	
		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		E. STREET AND NUMBER 721 Aldworth Road 21222	
5. SEX Male	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/12/22	9. AGE (In years last birthday) 50	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10B. KIND OF BUSINESS OR INDUSTRY Hecht. Co.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Patrick King		14. MOTHER'S MAIDEN NAME Margaret McHugh	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 215-16-6018		17. INFORMANT 4940 Eastern Avenue Baltimore, Maryland 21224 BCH: RECORDS	
18. 146.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Respiratory Failure (B) Oral Pharyngeal Cancer DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs 18 mo	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 9/26 19 22 to 9/27 19 22, that (1) (we) last saw the deceased alive on 9/27 19 22 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert Friedman MD		23B. DATE SIGNED 9/27/72		23C. PHYSICIAN'S NAME (Type) Robert Friedman, M.D.	
23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		23E. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.		23F. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/30/72		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith	
24D. LOCATION Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT. OCT 3 1972		24F. NAME OF REGISTRAR Sidney [unclear]	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

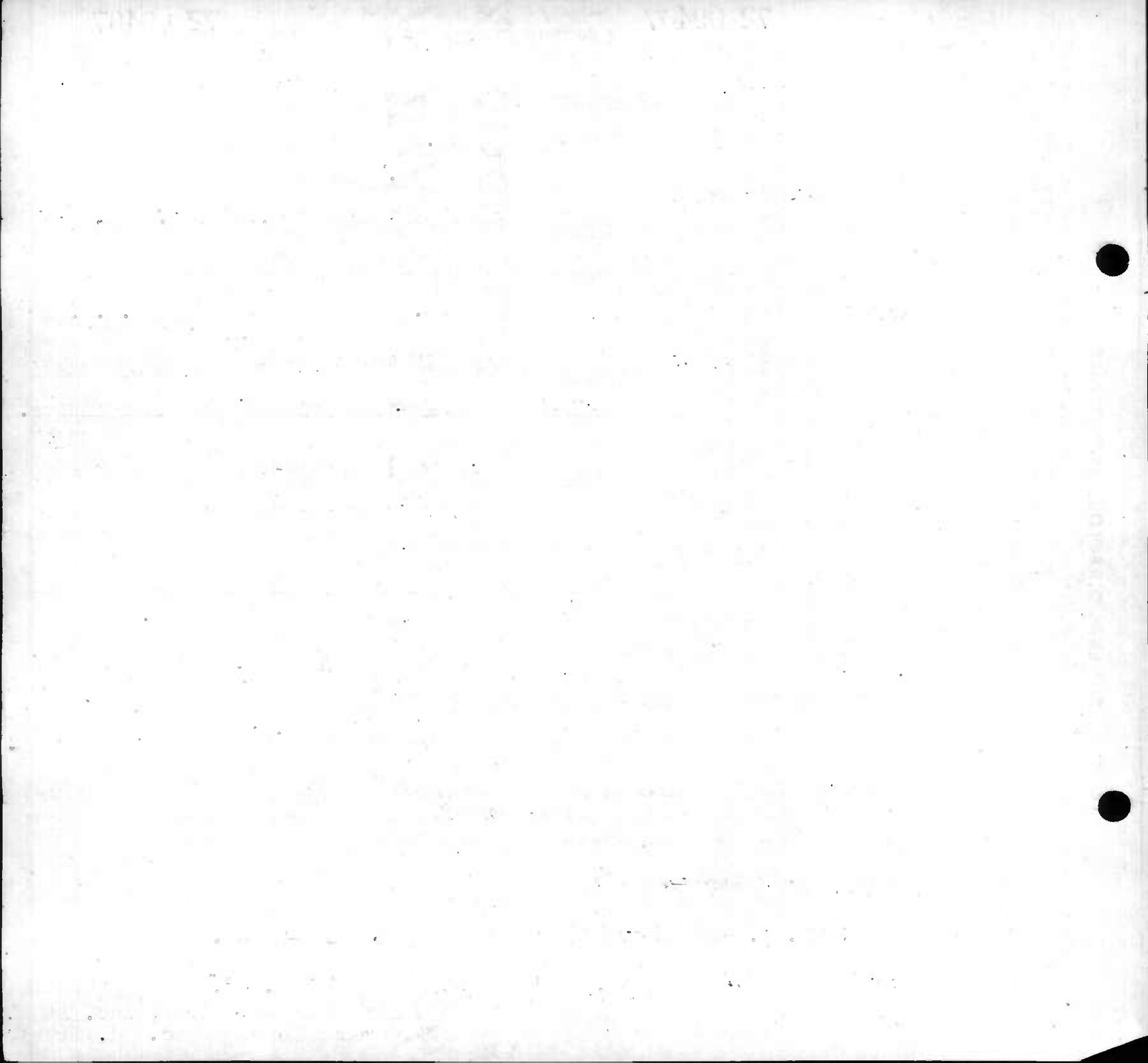
BALTIMORE CITY HEALTH DEPARTMENT				72-19406		72-19406	
CERTIFICATE OF DEATH				REG. NO.		STATE OF MARYLAND-DHMH	
BIRTH NO. <b>W-422</b>				1. NAME OF DECEASED (Type or Print) <b>Wilcox, Frank Richard</b>			
2. DATE AND HOUR OF DEATH <b>9-28-1972 AM 2:20</b>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</b>			
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>				C. CITY OR TOWN <b>Dundalk</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX <b>Male</b> 6. RACE <b>Caucasian</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>2-9-24</b> 9. AGE (In years last birthday) <b>48</b>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auditor - Govt.</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Ft. Holabird</b>			
11. BIRTHPLACE (State or foreign country) <b>W. Virginia</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Frank E. Wilcox</b>				14. MOTHER'S MAIDEN NAME <b>Frances S. Mayes</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WWII</b>				16. SOCIAL SECURITY NO. <b>234-28-9717</b>			
17. INFORMANT <b>BCH - RECORDS</b>				ADDRESS <b>4940 Eastern Avenue Baltimore, Maryland 21224</b>			
18. <b>431.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>Cerebral bleeding</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Hypertension</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>about 15 days</b> <b>about 1 month</b>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>II</b>							
19A. DATE OF OPERATION <b>0</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No) <b>No</b>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) <b>9-28-1972 AM 2:20</b>				21E. INJURY OCCURRED <b>While At Work</b>			
21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from <b>9-26</b> 19 <b>72</b> to <b>9-28</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>9-28</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Hiroshi Mitsuimoto, M.D.</b>				23B. DATE SIGNED <b>9-28-72</b>			
23C. PHYSICIAN'S NAME (Type) <b>HIROSHI MITSUMOTO, M.D.</b>				23D. ADDRESS <b>4940 E. Ave. Balb City Hosp</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>9/30/72</b>			
24C. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 3 1972</b>				25B. NAME OF REGISTRAR <b>John J. Duda</b>			
25C. FUNERAL DIRECTOR <b>John J. Duda</b>				ADDRESS <b>7922 Wise Ave. Dundalk, Md.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 69407</b>	
C-462 72 69407				STATE OF MARYLAND-DEMD	
BIRTH NO.				DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Katherine Hughes Clark</b>			2. DATE AND HOUR OF DEATH <b>10/1/72 1:05 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>90 Gould Nursing Home</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2633</b>		
5. SEX <b>F</b>			6. RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		8. DATE OF BIRTH <b>9/8/91</b>
13. FATHER'S NAME <b>William Hughes</b>			14. MOTHER'S MAIDEN NAME <b>Catherine Lennon</b>		9. AGE (In years last birthday) <b>81</b>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>213-74-8603</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>412.4 I</b>			19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Intend - cardiac</b> <b>Cardio-vascular disease</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
17. INFORMANT <b>Ida Weems (friend)</b>			ADDRESS <b>3236 Kenyon Ave.</b>		10. AGE (In years last birthday) <b>81</b>
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>August 1962</b> to <b>October 1972</b> , that (I) (we) last saw the deceased alive on <b>Sept 28 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Dr. J. Duer Moores</b>			23B. DATE SIGNED <b>10-2-72</b>		23C. PHYSICIAN'S NAME (Type) <b>Dr. J. Duer Moores</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>10/3/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Balto. Nat'l Cemetery</b>
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 3 1972</b>			25B. NAME OF REGISTRAR <b>Aisley H. Hottel</b>		25C. FUNERAL DIRECTOR <b>Schimmunek Funeral Homes, Inc.</b>
26A. ADDRESS <b>3331 Brehms Lane, Balto. Md. 21213</b>			26B. ADDRESS <b>3331 Brehms Lane, Balto. Md. 21213</b>		

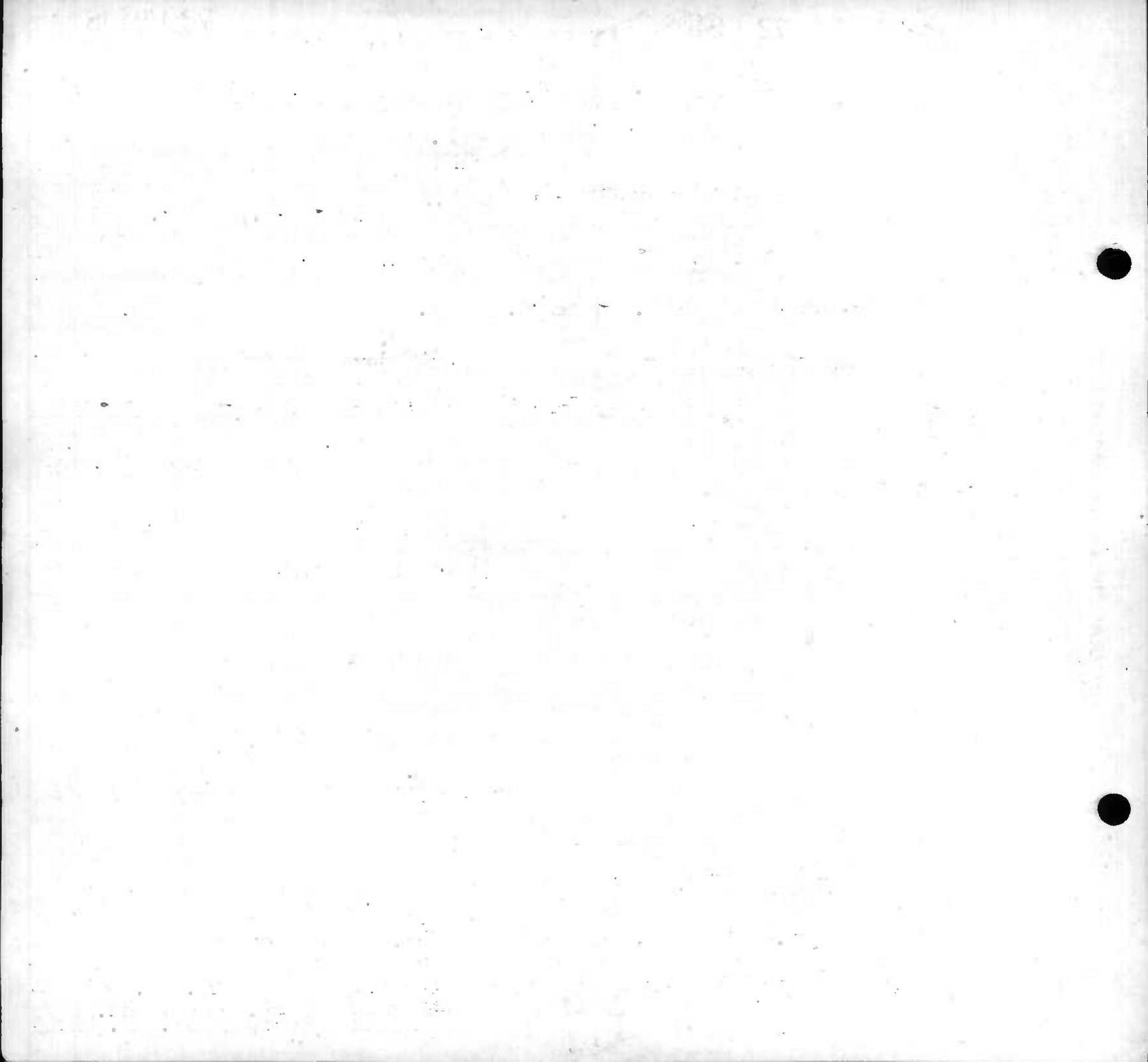




# FUNERAL DIRECTOR: IMPORTANT

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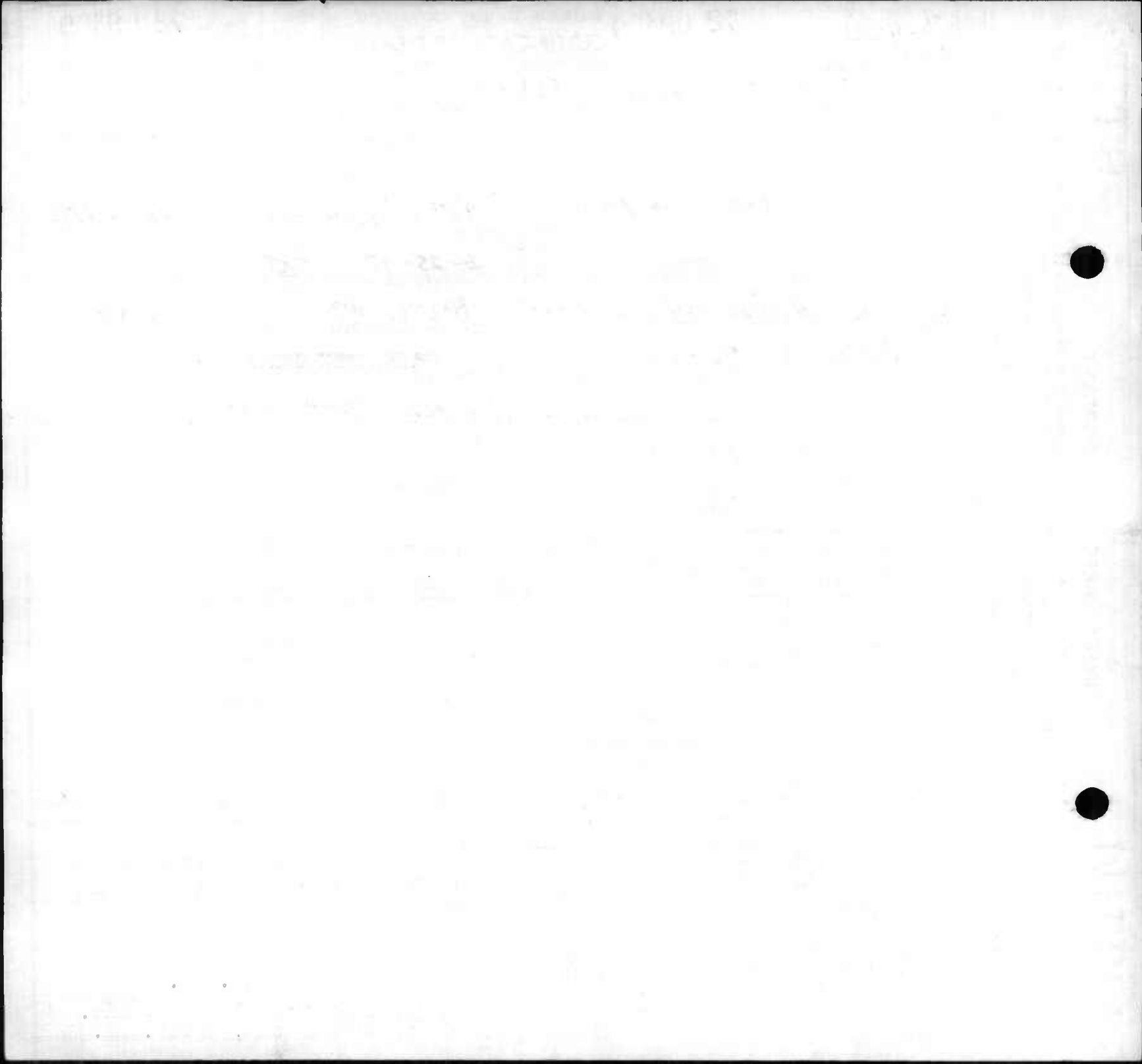
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 09408</b>	
H-400 72 09408				STATE OF MARYLAND-DEMENT	
BIRTH NO.				DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Seth L. Hall</b>				2. DATE AND HOUR OF DEATH <b>9/29/72 4:05 M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2643</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>90 House in Pines - Belair Rd.</b>				C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>3508 Lyndale Ave., Balto. 21213</b>	
5. SEX <b>M V W</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/16/02</b>	9. AGE (In years last birthday) <b>70</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lathe Operator</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
13. FATHER'S NAME <b>Richard Hall</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>				14. MOTHER'S MAIDEN NAME <b>Ruth Cox</b>	
16. SOCIAL SECURITY NO. <b>213-07-3392</b>				17. INFORMANT ADDRESS <b>Albina Hall (wife) same as above</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Acute bronchopneumonia</b> <b>Hypertension</b> <b>Obstructive Disease</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4-5 days</b> <b>year</b> <b>1 yr</b>	
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>June 5 1960</b> to <b>9-29 1972</b> , that (I) (we) lost saw the deceased alive on <b>9-28 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>William L. Fearing</b>				23B. DATE SIGNED <b>10-2-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. William L. Fearing</b>				23D. ADDRESS <b>3025 Belair Road</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/2/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Bohemian National Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 3 1972</b>			
25B. NAME OF FUNERAL DIRECTOR <b>Shirley M. Brown</b>		25C. FUNERAL HOME ADDRESS <b>Schimmeler Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21213</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 72 09409				72 09409	
CERTIFICATE OF DEATH				STATE OF MARYLAND - DHMH	
BIRTH NO. <u>7-450</u>		NAME OF DECEASED <u>SABINA AGNES FLYNN</u>		REG. NO. <u>72 09409</u>	
1. NAME OF DECEASED (Type or Print) <u>SABINA AGNES FLYNN</u>		2. DATE AND HOUR OF DEATH <u>28 September 1972 10155 A M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>44 UNION MEMORIAL HOSPITAL</u>		A. STATE <u>MARYLAND</u>		B. COUNTY <u>1307</u>	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>39th + BEECH AVE - WYMAN PK. APTS</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-25-97</u>	9. AGE (In years last birthday) <u>75</u>	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERICAL SUPERVISOR U.S. GOVERNMENT</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOVERNMENT</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO. MD</u>	
13. FATHER'S NAME <u>PATRICK FLYNN</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH CONCANNON</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-20-7866</u>		17. INFORMANT <u>NEPHEW - JOSEPH FLYNN 1341 CEDAR CROFT RD.</u>	
18. <u>569.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <u>SEPTIC SHOCK</u>			
ANTECEDENT CAUSES		(B) <u>PERITONITIS</u>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <u>SIGMOID DEFORATION.</u>			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, bldg., etc.) <u>Rd.</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>24 9 1972</u> to <u>28 9 1972</u> that (I) (we) lost saw the deceased alive on <u>29 9 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>John J. Mac Aul.</u>				23B. DATE SIGNED <u>28 19/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>DEGREE</u>				23D. ADDRESS <u>DEGREE</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/30/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 3 1972</u>			
25B. NAME OF REFERRED <u>20</u>		25C. FUNERAL DIRECTOR <u>53331 Breams Lane, Balto. Md. 21213</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09410		72 09410	
D-620				72 09410		72 09410	
BIRTH NO.				REG. NO.		STATE OF MARYLAND	
1. NAME OF DECEASED (Type or Print) <u>MARY F. DORSEY</u>				2. DATE AND HOUR OF DEATH <u>9/28/72</u> <u>1:30</u> <u>A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>34 Bon Secours Hospital</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>MARYLAND</u>		B. COUNTY <u>CARROLL</u>	
				C. CITY OR TOWN <u>SYKESVILLE 21784</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <u>RFD 2, BOX 203</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/23/11</u>	9. AGE (In years last birthday) <u>61</u>	If Under 1 Yr. Months: Days: Hours: Min. <u>7</u> <u>5</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Frederick Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Martin L. Fogle</u>				14. MOTHER'S MAIDEN NAME <u>Ina Belle Hann</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-09-3527</u>		17. INFORMANT <u>William H. Dorsey Same As #4.</u>			
18. <u>412.3 I</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs.</u>			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerotic H. D.</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>May 1971</u> to <u>9/28</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>9/28</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <u>C. Edward Leach</u>				23B. DATE SIGNED <u>9/28/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Dr. C. Edward Leach</u>	
				23D. ADDRESS <u>14 E. Eager St.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/2/1972</u>		24C. NAME OF CEMETERY or CREMATORY <u>Lakeview Memorial</u>		24D. LOCATION (City, town, or county) (State) <u>Carroll Co., Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 3 1972</u>		25B. NAME OF REGISTRAR <u>Anthony...</u>		25C. FUNERAL DIRECTOR <u>C.M. Waitz</u>		25D. ADDRESS <u>Box 326, Sykesville, Md.</u>	

U.S. DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

WATER RESOURCES DIVISION

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WATER RESOURCES DIVISION

1

STATE OF MARYLAND-DEME  
BALTIMORE CITY HEALTH DEPARTMENT

W-635 72 09411  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 72 09411

BIRTH NO. \_\_\_\_\_ REG. NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>KELLY WORTHAM</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> _____ M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>3002 W. North Ave. 11-24-72</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour M. <b>10 1 1972 11:45a</b>	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1506</b>			
6. SEX <b>male</b>	7. RACE <b>negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN <b>Balto.</b>
9. DATE OF BIRTH <b>328/34</b>		10. AGE (In years last birthday) <b>38</b>	E. STREET AND NUMBER <b>3002 W. North Ave.</b>
11. BIRTHPLACE (State or foreign country) <b>Bridgway NC</b>		12. CITIZEN OF WHAT COUNTRY?	13. FATHER'S NAME <b>Wallie M. Wortham</b>
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	15. MOTHER'S MAIDEN NAME <b>nothing</b>
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. <b>213-34604</b>	18. INFORMANT <b>Wallie M. Wortham</b> ADDRESS <b>196-02 100th Ave 3rd floor 74</b>
19. <b>57181</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH <b>Bronchopneumonia - Extensive portal fibrosis, liver</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>10-2-72</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>10/3/72</b>	24C. NAME OF CEMETERY or CREMATORY <b>Bridgway Cemetery</b>	24D. LOCATION (City, town, or county) (Note) <b>Bridgway NC</b>
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 3 1972</b>	25B. NAME OF REGISTRAR <b>Andrew L. Hooton</b>	25C. FUNERAL DIRECTOR <b>323 02 W North Ave</b>	ADDRESS <b>Baltimore</b>

VS 151-REV. 1/1/68

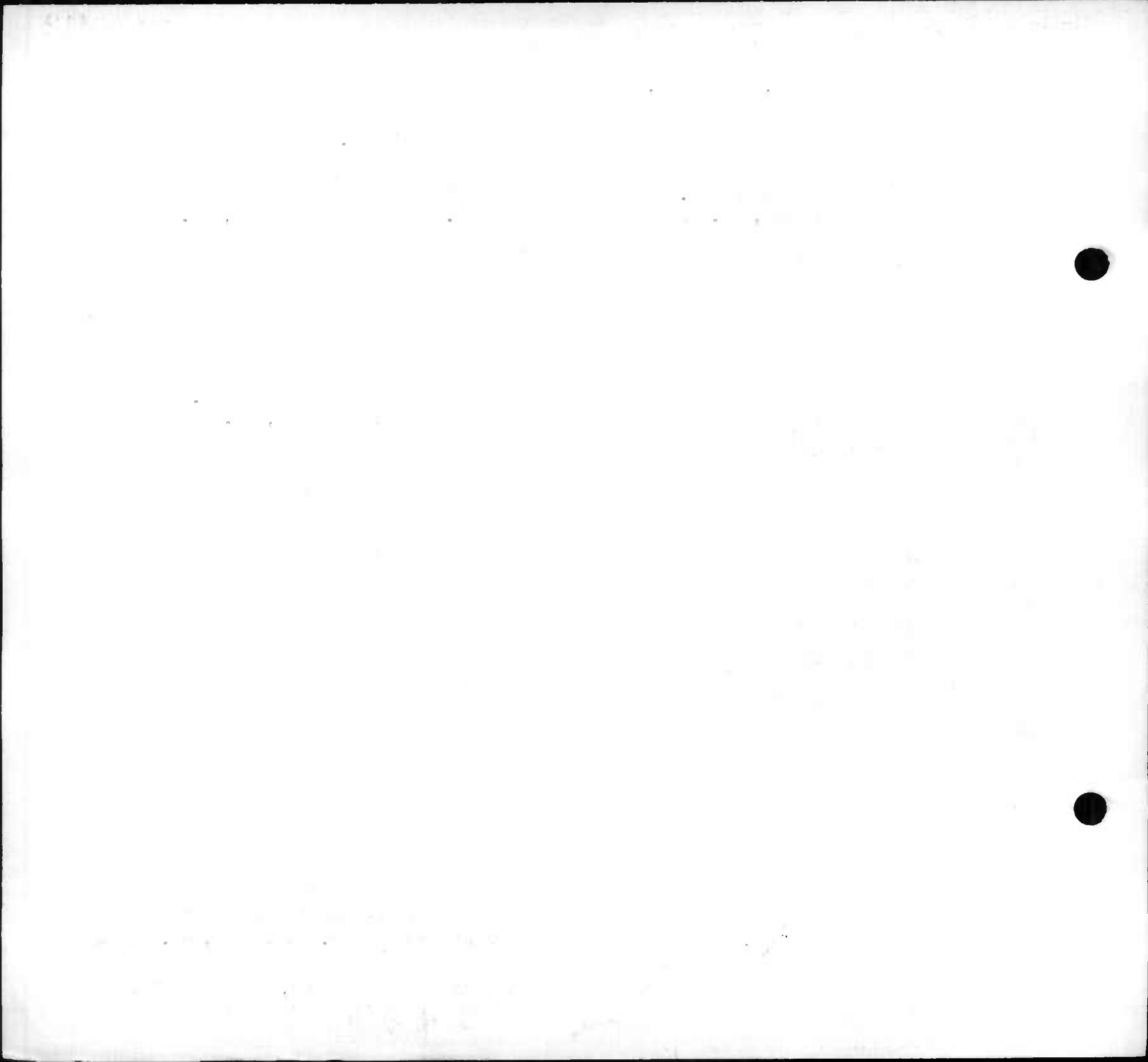


11-24-1972 - Letter from the Office of the Chief Medical Examiner,  
Russell S. Fisher, M.D. HS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-346 72 09412		BALTIMORE CITY HEALTH DEPARTMENT		72 09412	
BIRTH NO. Charles C. Md.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) Butler, Baby Girl, Linda "B"		2. DATE AND HOUR OF DEATH 9-24-72 11:05 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY St. Mary C. CITY OR TOWN Waldorf D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER Rt. 2 Box 206 Waldorf, Md. 20614			
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	9. AGE (In years last birthday)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Thomas		14. MOTHER'S MAIDEN NAME Linda			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT 4940 Eastern Ave. BCH Records: Baltimore, Md. 21224	
18. 769.4 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(A) IMMEDIATE CAUSE Due to, or as a consequence of: Cardiopulmonary arrest (B) Immaturity Due to, or as a consequence of: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-22-72 to 9-24-72 1972 that (I) (we) last saw the deceased alive on 9-24-72 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Vilaywan Thitiyaran		23B. DATE SIGNED 9-24-72		23C. PHYSICIAN'S NAME (Type) VILAYWAN THITIYARANA	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 9-27-72		24C. NAME OF CEMETERY or CREMATORY Baltimore City Hospitals	
24D. LOCATION Baltimore, Maryland		24E. STREET AND NUMBER 21224		24F. CITY, TOWN, or COUNTY Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. OCT 3 1972		25B. NAME OF REGISTRAR S. J. H. H. H.		25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL	



## CERTIFICATE OF DEATH

REG. NO.

72 09413

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Butler, Baby Girl, Linda "A"

2. DATE AND HOUR OF DEATH

9-24-72

4:20 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)Baltimore City Hospitals  
4940 Eastern Ave.  
Baltimore, Md. 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland St. Mary

C. CITY OR TOWN

Waldorf

D. INSIDE CITY LIMITS?

YES ☐NO ☐

E. STREET AND NUMBER

Rt. 2 Box 206 Waldorf, Md. 20614

5. SEX

Female

6. RACE

Negro

7. MARRIED ☐NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

9. AGE (In years  
last birthday)If Under 1 Yr.  
MonthsIf Under 24 Hrs.  
Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Thomas

14. MOTHER'S MAIDEN NAME

Linda

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

4940 Eastern Ave. ADDRESS

BCH Records: Baltimore, Md. 21224

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 9-23 19 72 to 9-24 19 72  
that (I) (we) last saw the deceased alive on 9-24 19 72 and that (in my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S  
NAME (Type)

DEGREE

Attending ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

Sept. 24, 1972

23D. ADDRESS

Baltimore City Hospitals  
4940 Eastern Ave. Baltimore, Md. 2122424A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town or county) (State)

Cremation

9-27-72

Baltimore City Hospitals

Baltimore, Maryland 21224

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL OR OTHER DISPOSITION

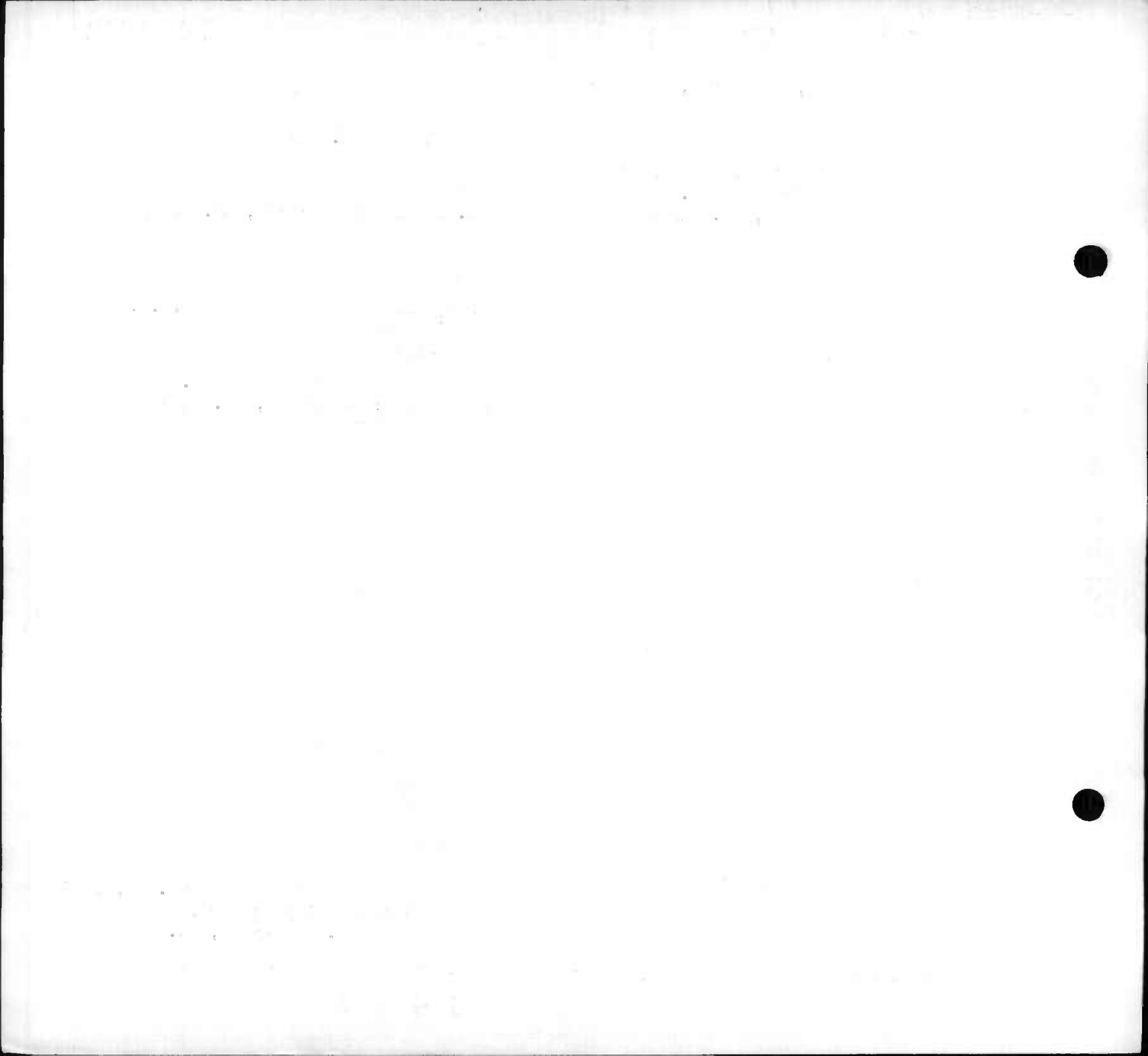
ADDRESS

OCT 3 1972

HOSPITAL DISPOSAL

FUNERAL DIRECTOR: IMPORTANT

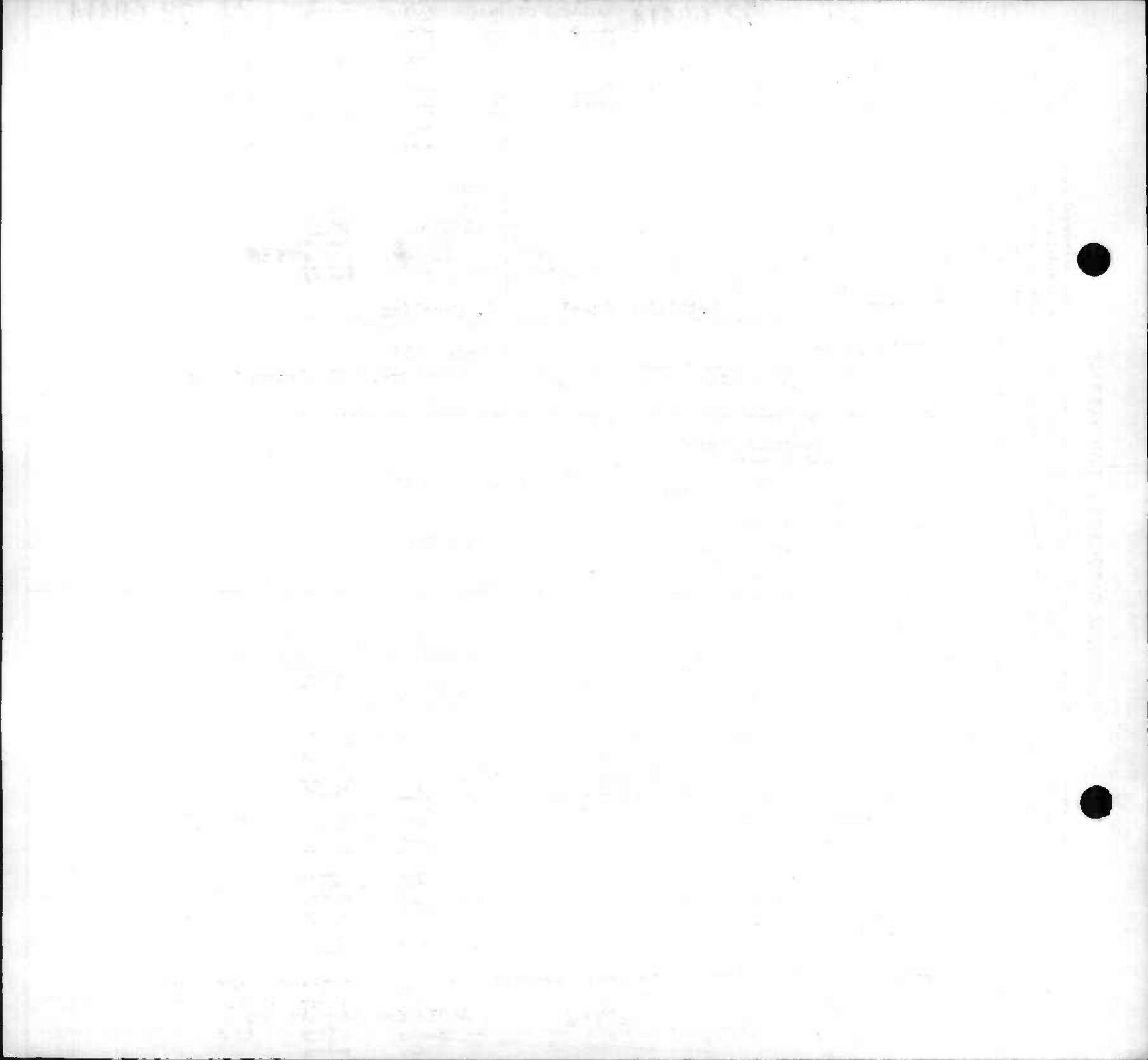
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

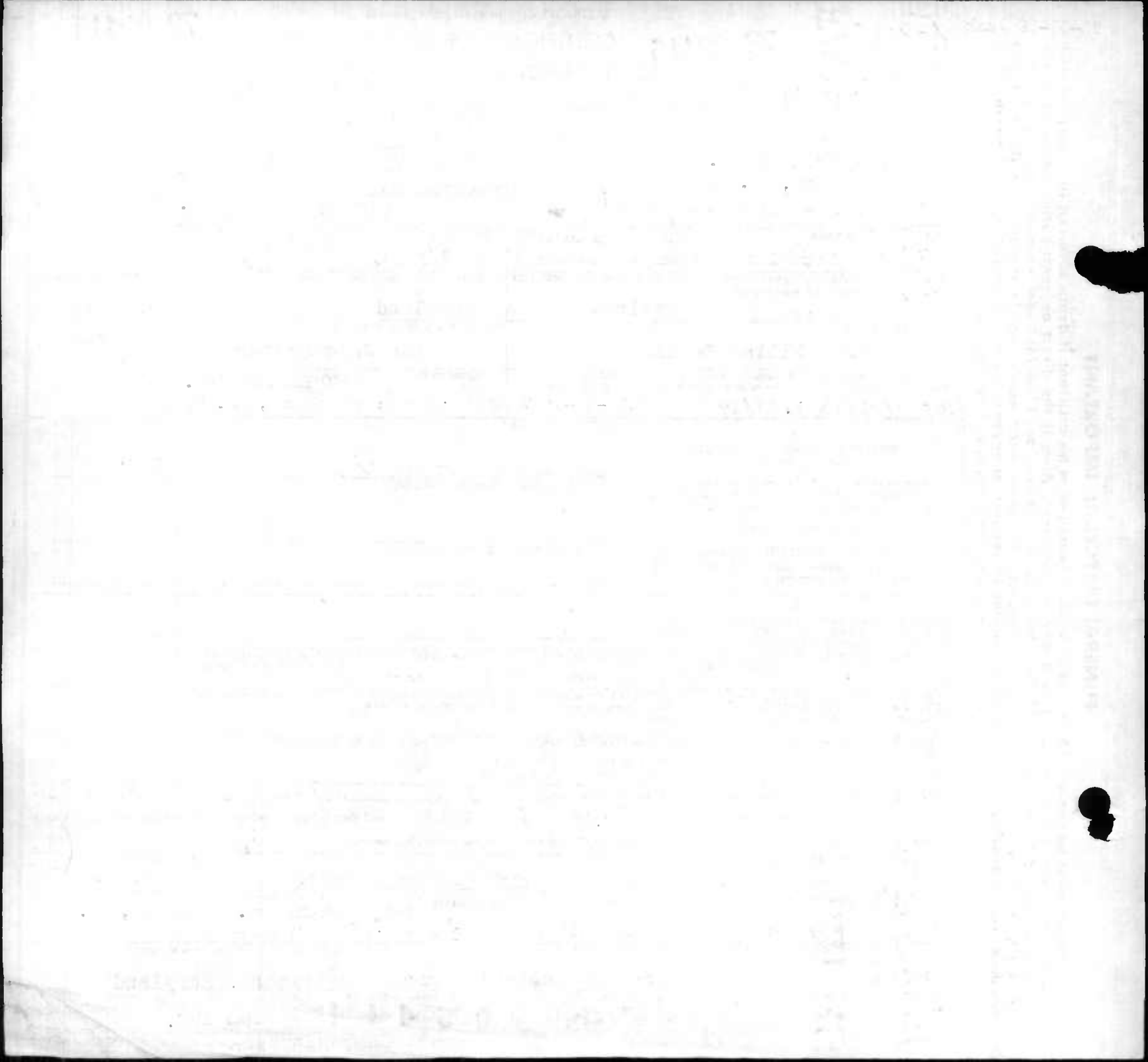
<b>72 09414</b> REG. NO. <b>72 09414</b> <b>STATE OF MARYLAND-DHMH</b>		<b>CERTIFICATE OF DEATH</b>	
BIRTH NO. <b>S-162</b> 1. NAME OF DECEASED (Type or Print) <b>SPEARS, William</b>		2. DATE AND HOUR OF DEATH <b>10/2/72 4:30 a.m.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>PROVIDENT HOSPITAL</b> <b>39</b>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2844</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>710 Walnut Ave.</b>	
5. SEX <b>male</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/26/19</b> 9. AGE (In years last birthday) <b>53</b> If Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Bethlehem Steel</b>	
11. BIRTHPLACE (State or foreign country) <b>S. Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Mallie Spears</b>		14. MOTHER'S MAIDEN NAME <b>Mamie Bell</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>911-19-4348</b>	
17. INFORMANT <b>Mrs. Wilhelmina Spears</b> <b>wife</b>		ADDRESS <b>710 Walnut Ave 21229</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>162-19-011-9</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> <b>Lung cancer</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Right upper lobe resection, PTB</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/18</b> 19 <b>72</b> to <b>10/2</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>10/2</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>A. Agustin</b>		23B. DATE SIGNED <b>10/2/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>C. E. AGUSTIN</b>		23D. ADDRESS <b>Provident Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-5-1972</b>	
24C. NAME of CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 3 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Whitson</b>	
25C. FUNERAL DIRECTOR <b>Edmondson Avenue</b>		ADDRESS <b>Purnell B. Oden 21229</b>	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>T-125</b>		72 09415		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 09415</b>	
NAME OF DECEASED (Type or Print) <b>Tapking George</b>		GEORGE HENRY TAPKING		DATE AND HOUR OF DEATH <b>8/30/72</b>		<b>8:27 M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2605</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>4940 Eastern Ave. Baltimore, Md. 21224</b> <b>Baltimore City Hospital</b>				C. CITY OR TOWN <b>Balti</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				E. STREET AND NUMBER <b>453 Anglesca St. 21224</b>			
5. SEX <b>Male</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/21/96</b>	9. AGE (In years last birthday) <b>76</b>	11. Under 1 Yr. Months: Days: Hours: Min.	12. Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Policeman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry William Tapking</b>				14. MOTHER'S MAIDEN NAME <b>Ida Jane Coster</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 8/21/18 1/27/19</b>		16. SOCIAL SECURITY NO. <b>220-44-7597</b>		17. INFORMANT <b>4940 Eastern Ave. Address</b> <b>BCH Records: Baltimore, Md. 21224</b>			
18. <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ASCVD</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>1/9/28</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>incision @ femoral art.</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/> <b>Notify medical examiner</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>9/28</b> 19 <b>72</b> to <b>9/30</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>8:25pm 9/30</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>David L. Curtis M.D.</b>				23B. DATE SIGNED <b>9/30/72</b>		23C. PHYSICIAN'S NAME (Type) <b>Curtis, David L. MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/4/72</b>		24C. NAME of CEMETERY or CREMATORY <b>First Evangelical Church</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 3 1972</b>		25B. NAME OF REGISTRAR <b>Henry Sander &amp; Sons Inc.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>BALTIMORE, MARYLAND</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X	
BIRTH NO.		72 09416		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		REG. NO. 72 09416	
HARTMAN, Herman		9/28/72		7:15 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218		A. STATE B. COUNTY C. CITY OR TOWN D. INSIDE CITY LIMITS? E. STREET AND NUMBER F. ZIP CODE			
Male		White		11-18-88	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Blacksmith		Pennsylvania		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
George L. Hartman		Margaret Wrightnatta			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
Yes		9-28-18 to 12-9-18		Records	
18. CAUSE OF DEATH		18. SOCIAL SECURITY NO.		17. INFORMANT	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		18. SOCIAL SECURITY NO.		VAH, 3900 Loch Raven Blvd., Balto., Md. 21218	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		18. SOCIAL SECURITY NO.		VAH, 3900 Loch Raven Blvd., Balto., Md. 21218	
ANTECEDENT CAUSES		18. SOCIAL SECURITY NO.		VAH, 3900 Loch Raven Blvd., Balto., Md. 21218	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		18. SOCIAL SECURITY NO.		VAH, 3900 Loch Raven Blvd., Balto., Md. 21218	
II		18. SOCIAL SECURITY NO.		VAH, 3900 Loch Raven Blvd., Balto., Md. 21218	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		18. SOCIAL SECURITY NO.		VAH, 3900 Loch Raven Blvd., Balto., Md. 21218	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2		C.O.P.D., ANEMIA		Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (he) (this hospital) attended the deceased from September 21 19 72 to September 28 19 72, that (he) (we) last saw the deceased alive on September 28, 19 72 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) view the body after death.		23A. SIGNATURE		23B. DATE SIGNED	
Thomas E. Murphy, Jr.		23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
Burial		24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
OCT 3 1972		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
OCT 3 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
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OCT 3 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
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OCT 3 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
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OCT 3 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
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OCT 3 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
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OCT 3 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
OCT 3 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
OCT 3 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	

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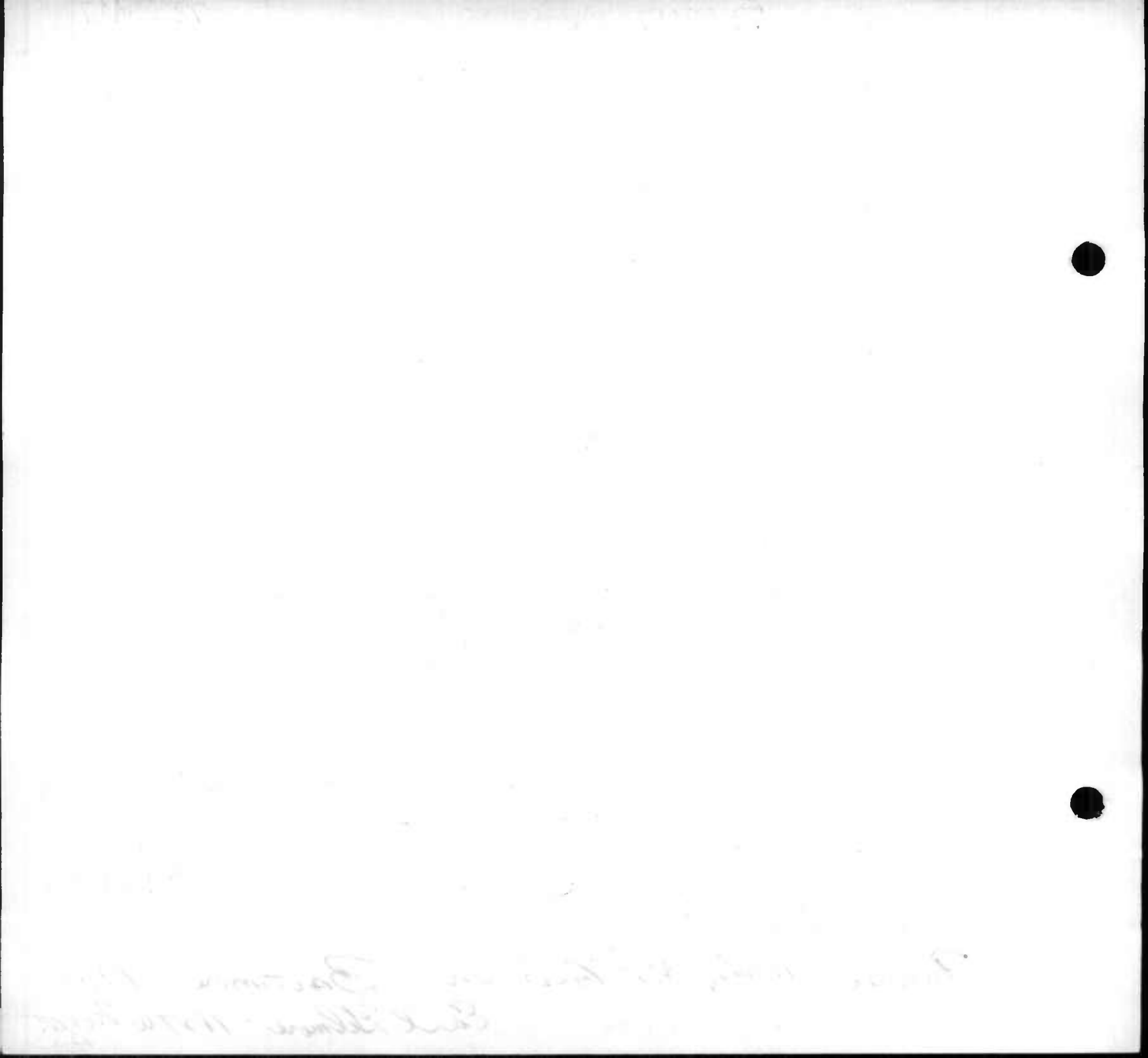
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-452		72 09417		BALTIMORE CITY HEALTH DEPARTMENT		72 09417	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <u>Williams Frances</u>				2. DATE AND HOUR OF DEATH <u>9-30-72</u> <u>1:12:30 pm</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>90 Mt. Sinai Nursing Home</u> <u>4613 Park Heights Ave.</u>				A. STATE <u>Maryland</u> B. COUNTY <u>1402</u>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <u>1620 Druid Hill Ave</u>				21217			
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-18-99</u>	9. AGE (In years last birthday) <u>73</u>	If Under 1 Yr. Months	If Under 1 Yr. Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
18. <u>438.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <u>Involuntarily</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Senile cerebrovascular disease</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Recurrent attack of heart failure</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>None</u>				ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>9/15</u> 19 <u>72</u> to <u>9/30</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>9/15</u> 19 <u>72</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>10/2/72</u>			
23C. PHYSICIAN'S NAME (Type) <u>VASH</u>				23D. ADDRESS <u>[Address]</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10/4/72</u>		<u>Mt. Auburn</u>		<u>Baltimore Md</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
<u>OCT 3 1972</u>		<u>Ardeny H. Hoston</u>		<u>Earl Helmore - 18276 Hovos Ave</u>			



Handwritten text at the bottom of the page, likely bleed-through from the reverse side. The text is mirrored and difficult to decipher, but appears to include the words "The" and "the" in a cursive script.

1

72 09418 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 09418

BIRTH NO.

STATE OF MARYLAND-DEMH

1. NAME OF DECEASED  
(Type or Print)

JOHN H. FELTON, JR.

2. DATE  
OF DEATHKnown ☐  
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Lutheran Hospital (DOA)

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Md.

B. COUNTY

1506

6. SEX

male

7. RACE

negro

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

5-10-1923

10. AGE (In years  
last birthday)

49

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

2912 Presbury St.

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY?  
USA

13. FATHER'S NAME

John H. Felton Sr.

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Disabled Veteran

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Alice Burrell

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

World War II

17. SOCIAL  
SECURITY NO.

229-16-1992

18. INFORMANT

ADDRESS

Mrs. Alice Felton 2912 Presbury Street

19. 412.41

CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, osteoarthritis, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒  
ASSISTANT MEDICAL EXAMINER ☐  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9-25-72

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

9-28-72

24C. NAME OF CEMETERY or CREMATORY

Arbutus Memorial Park

24D. LOCATION (City, town, or county)

Baltimore Co., Maryland

25A. DATE REC'D BY HEALTH DEPT.

OCT 3 1972

25B. NAME OF REGISTRAR

Adney Thornton

25C. FUNERAL DIRECTOR

NUTTER FUNERAL HOME 3035 W. NORTH AVE

ADDRESS



Administrative and Technical Services

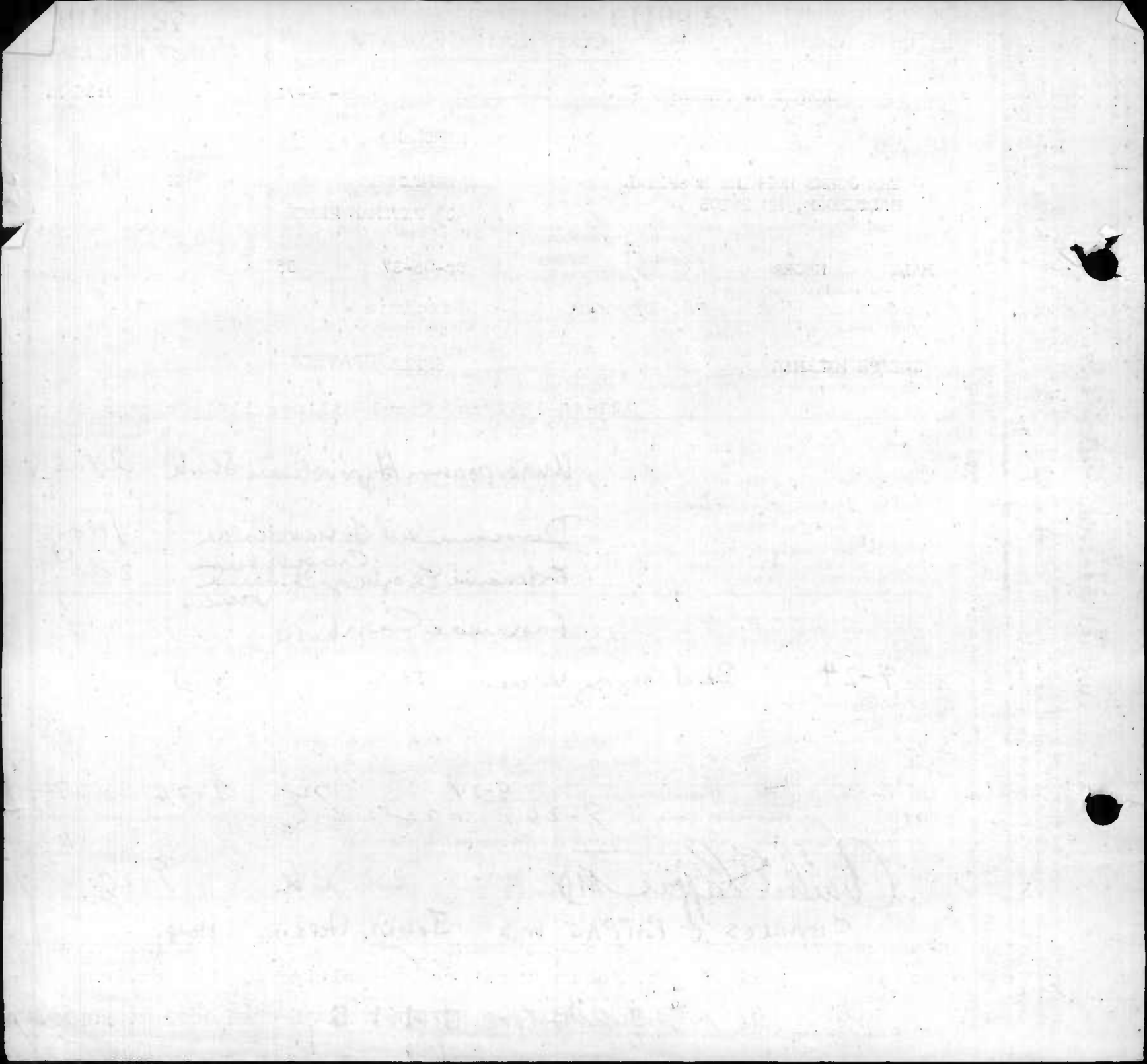
*Handwritten signature*

Donald E. Smith, Jr.

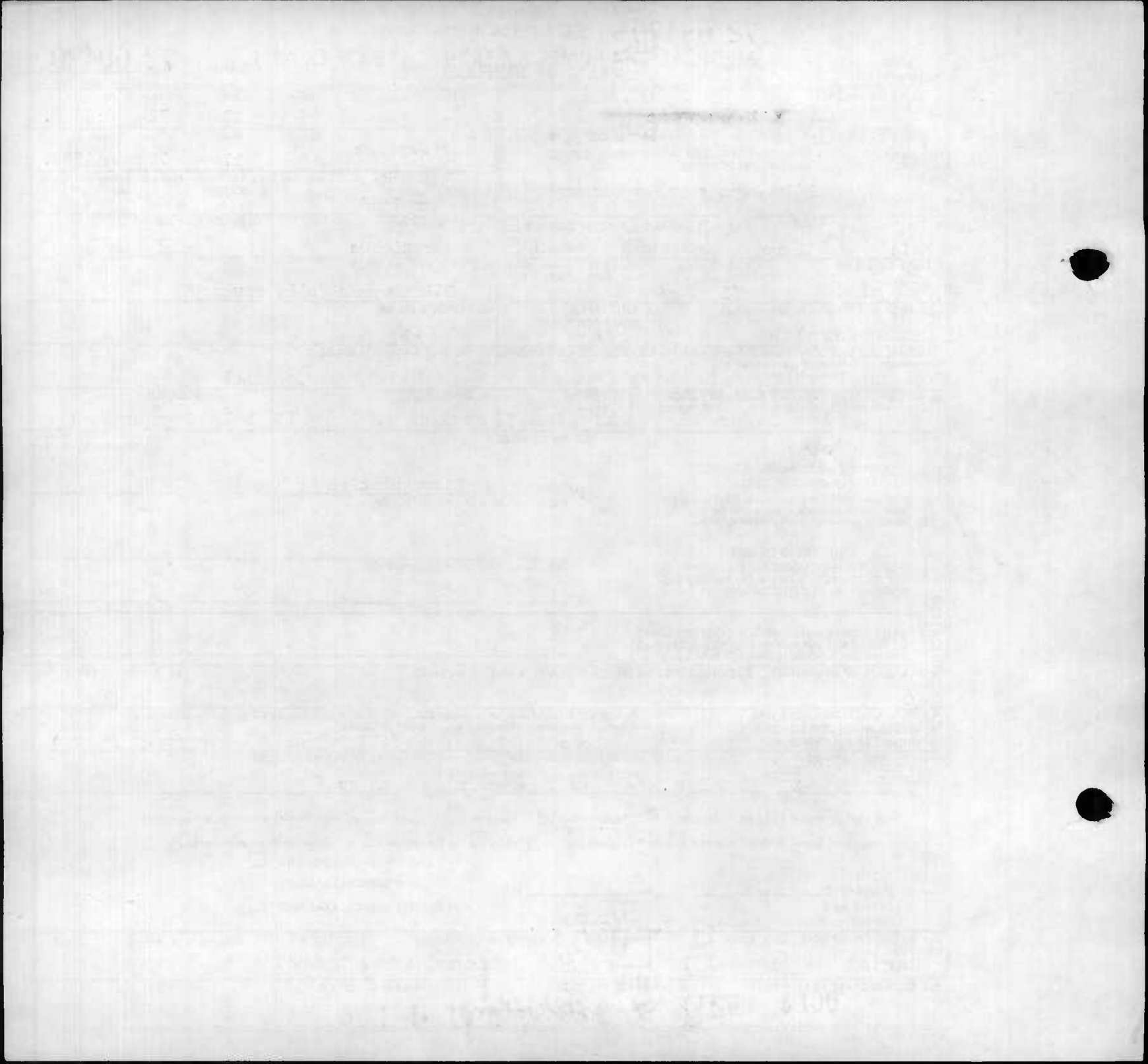
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 09419 CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72 09419	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		SIDNEY R. MILLNER SR.		09-26-72 9:36 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205				MARYLAND	
				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER	
				422 PITTMAN PLACE	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MALE	NEGRO	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	06-05-37	35	Welder
		11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?		108. KIND OF BUSINESS OR INDUSTRY
		Virginia	USA		Md. Drydock
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
JOSEPH MILLNER			EFFIE GRAVELY		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
No		223-46-1552	Mrs. Carol Millner 1101 Orleans Street		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		Chronic progressive Hypertension Stroke 2 days			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Disseminated Intravascular Coagulation 1 day			
		(C) Extensive Esophageal bleed Varices 2 days			
		Laryngeal Carcinoma			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
9-24		Esophageal Varices		Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 9-24 1972 to 9-26 1972, that (I) (we) last saw the deceased alive on 9-26 1972 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Charles E. Pappas MD				9-26	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
CHARLES E. PAPPAS MD				JOHNS HOPKINS HOSP.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		9-30-72		Mt. Auburn Cemetery	
				Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
OCT 3 1972		Sidney R. Millner		NUTTER FUNERAL HOME 3035 W. NORTH AVE	







FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 09421

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

72 09421

STATE OF MARYLAND - DEPT

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

WILLIAM E. WARDEN

2. DATE AND HOUR OF DEATH

Sept. 30 1972

7:45 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Provident Hospital

39

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Catonsville

D. INSIDE CITY LIMITS?

YES ☐

NO ☒

E. STREET AND NUMBER

102 WINTERS LANE

5. SEX

Male

6. RACE

Negro

7. MARRIED ☒

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

05-04-04

9. AGE (In years last birthday)

68

If Under 1 Yr. Months

If Under 24 Hrs. Days

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

uffer

10B. KIND OF BUSINESS OR INDUSTRY

Caton Chapman Fuel Co.

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Howard Warden

14. MOTHER'S MAIDEN NAME

Gussie Law

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

216093286

17. INFORMANT

Amy Warden-102 Winters Lane

ADDRESS

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

Acute Renal Failure

1 month

DUE TO, OR AS A CONSEQUENCE OF:

(B)

Urinary obstruction + septicemia

DUE TO, OR AS A CONSEQUENCE OF:

(C)

Benign Prostatic hypertrophy

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

8/25/72

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

urinary obstruction

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from August 11 1972 to Sept 30 1972 that (I) (we) lost saw the deceased alive on Sept 30 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Rodolfo Quion MD

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

Sept. 30 1972

23C. PHYSICIAN'S NAME (Type)

Rodolfo Quion M.D.

23D. ADDRESS

Provident Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10/4/72

24C. NAME OF CEMETERY or CREMATORY

Arbutus Memorial park

24D. LOCATION

(City, town, or county)

Baltimore Co., Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

OCT 3 1972

25B. NAME OF REGISTRAR

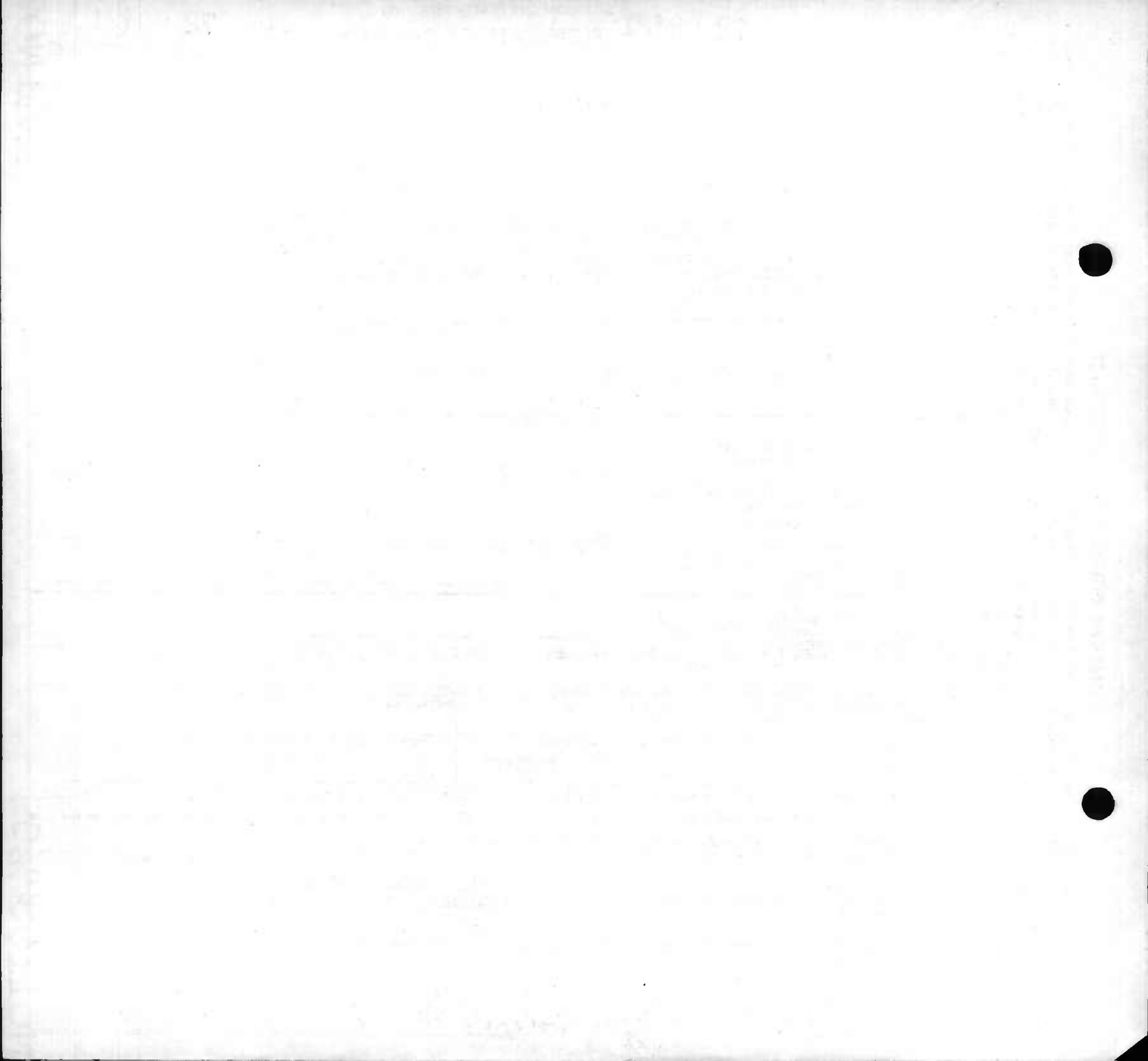
Adrian J. [Signature]

25C. FUNERAL DIRECTOR

Herbert E. Nutter

ADDRESS

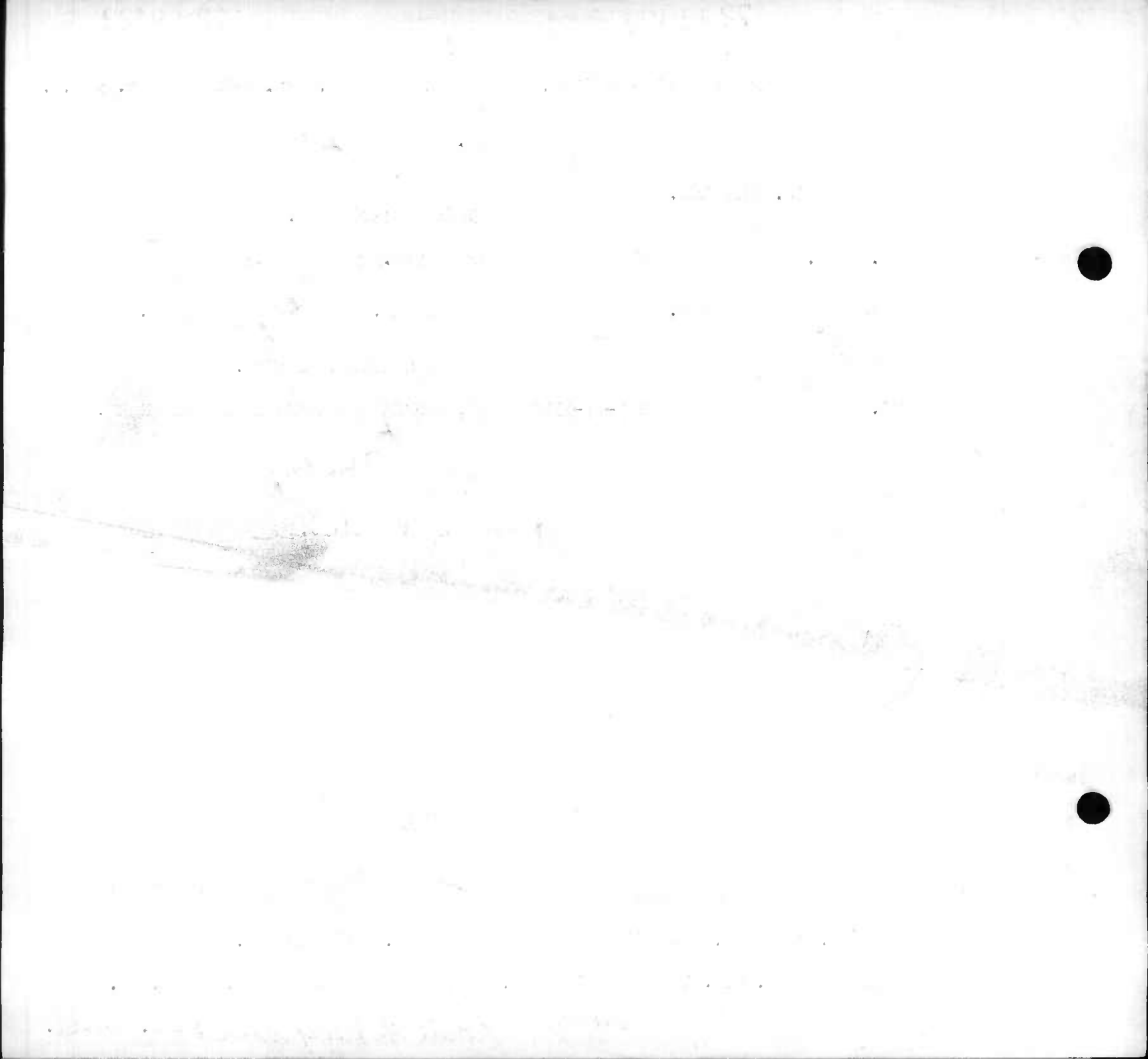
3035 W. North Ave





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

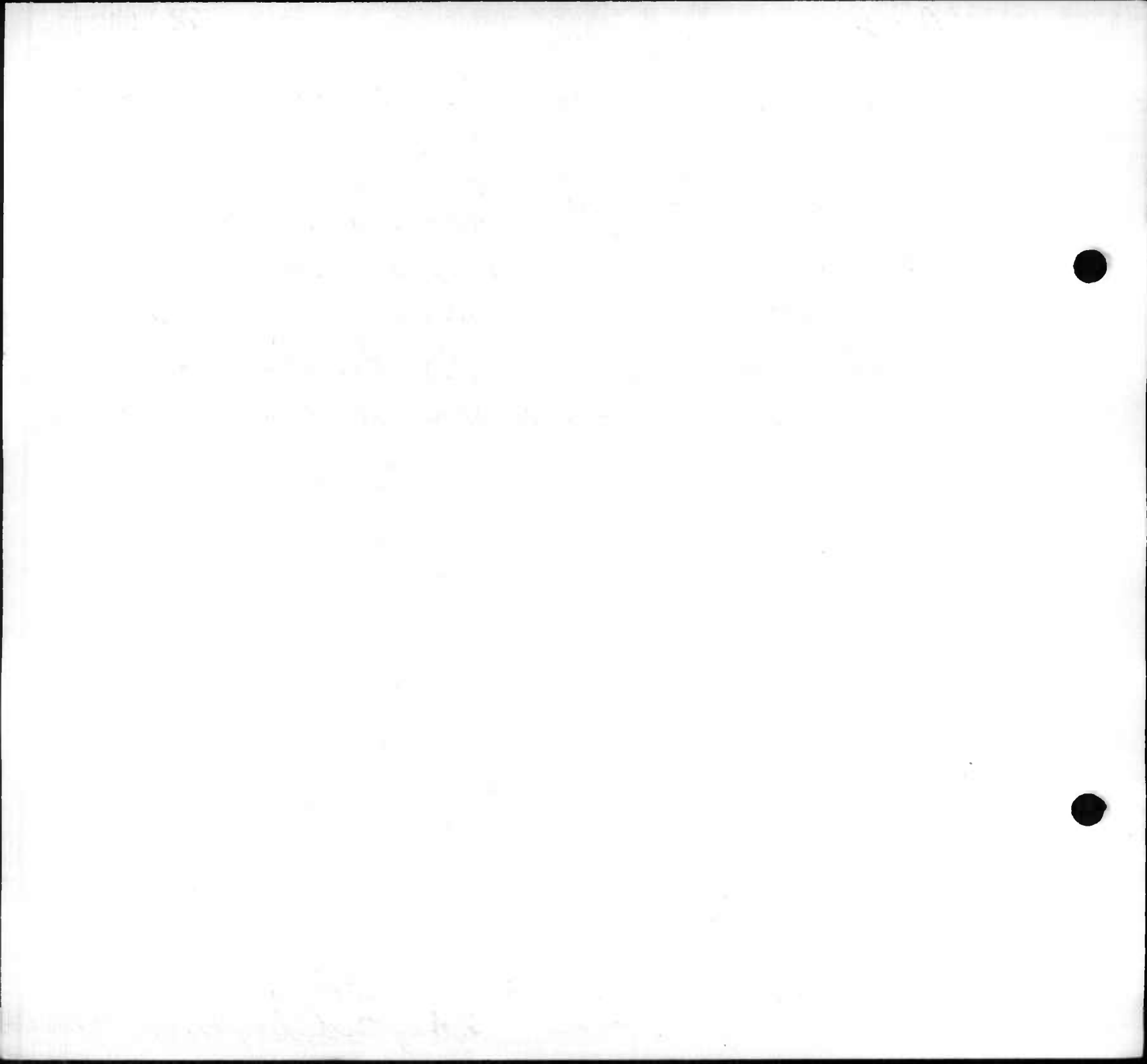
72 09422		BALTIMORE CITY HEALTH DEPARTMENT		72 09422			
P-4302 P-630		72 09422		BALTIMORE CITY HEALTH DEPARTMENT			
BIRTH NO.		REG. NO.		STATE OF MARYLAND - DEPT. HEALTH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
JOSEPHINE PIRATO OR PILATO.		OCT. 1st. 1972 6.55 P.M.		FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			
31 BALTO. CITY HOS.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		Md. BALTO?			
5. SEX F. W.		6. RACE F. W.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH APRIL 5th./05		9. AGE (In years last birthday) 67		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			
11. BIRTHPLACE (State or foreign country) ITALY.		12. CITIZEN OF WHAT COUNTRY? ITALY.		13. FATHER'S NAME JOSEPH PIRATO			
14. MOTHER'S MAIDEN NAME IDA OR AGATHA LA MURA.		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO.		16. SOCIAL SECURITY NO. 213-07-3320			
17. INFORMANT MRS. BESSIE DI BLASIO 1811 WEYBURN RD.		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from 19 68 to 19 72 and that (I) (we) last saw the deceased alive on 8/27/72 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE 23B. DATE SIGNED 23C. PHYSICIAN'S NAME (Type) 23D. ADDRESS 24A. BURIAL CREMATION, REMOVAL (Specify) 24B. DATE 24C. NAME of CEMETERY or CREMATORY 24D. LOCATION (City, town, or county) (State) 25A. DATE REC'D BY HEALTH DEPT. 25B. NAME OF REGISTRAR 25C. FUNERAL DIRECTOR 25D. ADDRESS		25. DATE REC'D BY HEALTH DEPT. OCT 3 1972		25B. NAME OF REGISTRAR Sidney H. Heston	
25C. FUNERAL DIRECTOR James M. O'Leary		25D. ADDRESS 322 S. HIGH ST.		25E. DATE REC'D BY HEALTH DEPT. OCT 3 1972			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 09423		72 09423	
BIRTH NO.		72 09423		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		STATE OF MARYLAND - DEPT. M.	
PETERSON, MARY FRANCES		10-2-72		2:45	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE	
FULL NAME OF HOSPITAL OR INSTITUTION		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		B. COUNTY	
46 Lutheran Hospital		Baltimore, Md.		Maryland	
C. CITY OR TOWN		D. INSIDE CITY LIMITS?		E. STREET AND NUMBER	
Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1123 Harlem Ave	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
F		B		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH		9. AGE (in years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
5-30-28		44		House Wife	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
Md.		U. S.		Merrill Ray	
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
Martha Braddis		No		216-24-7671	
17. INFORMANT		ADDRESS		18. CAUSE OF DEATH	
James H. Peterson		(SAME)		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		ANTECEDENT CAUSES		DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	
(A) IMMEDIATE CAUSE		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
Hepatic Coma		Cirrhosis of Liver		Infectious Hepatitis	
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Anemia	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
No		No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		22. I certify that (I) (this hospital) attended the deceased from 10-1-1972 to 10-2-1972 that (I) (we) last saw the deceased alive on 10-2-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
J. H. Stoddi		10/2/72		J. H. Stoddi, M.D.	
23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
Lutheran Hospital		Burial		10/5/72	
24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT.	
Cedar Hill		A A Co Md.		OCT 3 1972	
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS	
L. H. Stoddi		Baltimore Phillips 1727 N. Mount		1727 N. Mount	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				CERTIFICATE OF DEATH		REG. NO. 72 09424	
B-650 72 09424							
1. NAME OF DECEASED (Type or Print) <b>BROWN, ELWOOD L.</b>				2. DATE AND HOUR OF DEATH <b>9/29/72 9:05 PM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1502</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>UNION MEMORIAL HOSPITAL</b> <b>433 N. Calvert St Baltimore, Md 21218</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>MALE</b> 6. RACE <b>BLACK</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>03/07/18</b>		9. AGE (In years last birthday) <b>54</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>POLICEMAN</b>				11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN</b>	
13. FATHER'S NAME <b>GARFIELD BROWN</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN Ruth Jones</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WWII</b>				16. SOCIAL SECURITY NO. <b>214-14-4332</b>		17. INFORMANT <b>Service Brewer</b>	
18. <b>188X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>CARDIO-RESPIRATORY ARREST</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>MULTIPLES METASTASIS</b> <b>CARCINOMA OF BLADDER</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>11 years</b> <b>11 year</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>II</b>							
19A. DATE OF OPERATION <b>8/24/72</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>INTESTINAL OBSTRUCTION</b>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>07/27/72</b> 19 to <b>09/29/72</b> 19, that (I) (we) lost saw the deceased alive on <b>09/29/72</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>A. Guzman</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>9/29/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>A. GUZMAN</b>				23D. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-3-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Maryland National</b>		24D. LOCATION (City, town, or county) (State) <b>Laurel Md.</b>	
25A. DATE OF HEALTH DEPT. REPT. <b>OCT 3 1972</b>		25B. NAME OF REGISTRAR <b>Anthony H. Wilson</b>		25C. FUNERAL DIRECTOR <b>William Phillips</b>		ADDRESS <b>1727 N. Mount St.</b>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>NATHAN P. MC MEANS</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>00 4212 Groveland Ave.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>10 2 1972 6:55a</b> M.	
6. SEX <b>male</b>		7. RACE <b>negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>6-23-55</b>		10. AGE (In years lost birthday) <b>17</b> If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. <b>214-68-3833</b>	
18. INFORMANT <b>Julian P. Mc Means</b>		ADDRESS <b>Same</b>	
19. <b>345.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Epilepsy</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>R. S. Fisher</b> M.D. EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>10-2-72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/4/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Cedar Hill</b>		24D. LOCATION (City, town, or county) (State) <b>A.A. Co. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 3 1972</b>		25B. NAME OF REGISTRAR <b>Lindsey</b>	
25C. FUNERAL DIRECTOR <b>William S. Phillips</b>		ADDRESS <b>1727 N. Monmouth St.</b>	

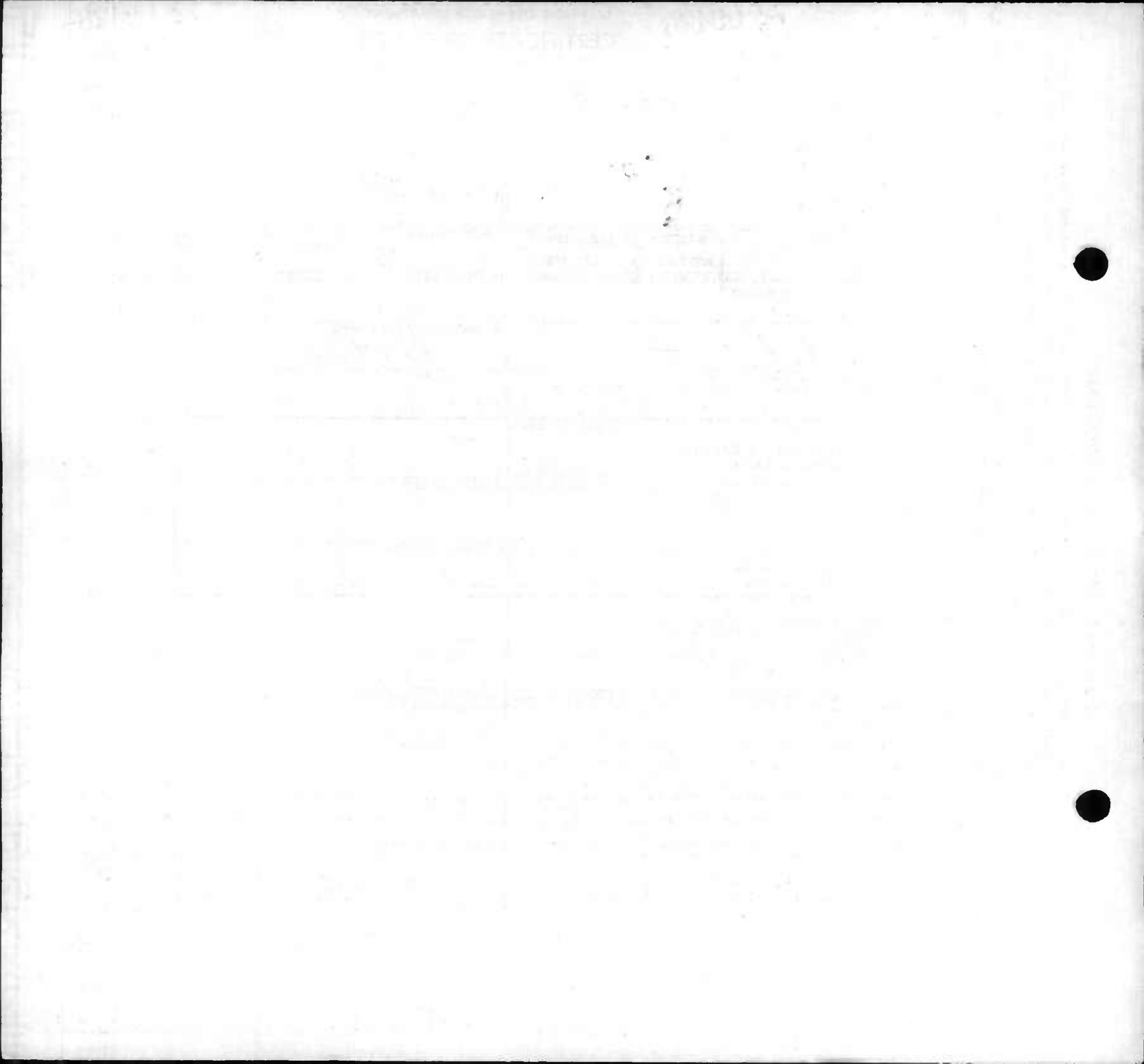




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09426	
CERTIFICATE OF DEATH				REG. NO. 72 09426	
BIRTH NO. <u>P.613</u>		ALIAS: <u>HENRY E. PRIVETT SR.</u>		DATE AND TIME OF DEATH <u>SEP. 29, 1972 11:30 P.M.</u>	
1. NAME OF DECEASED (Type or Print) <u>EDDIE H. PRIVETTE, SR.</u>		2. DATE AND TIME OF DEATH			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived) If institution: residence before admission		A. STATE <u>MARYLAND</u> B. COUNTY <u>1302</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<u>PROVIDENT HOSPITAL</u>		<u>BALTIMORE</u>			
<u>BALTIMORE, M.D.</u>		E. STREET AND NUMBER		<u>2231 Entwistle Place</u>	
5. SEX <u>M</u>	6. RACE <u>B</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/15/03</u>	9. AGE (In years last birthday) <u>68</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>Farmer + Gardener</u>				<u>N.C.</u>	
12. CITIZEN OF WHAT COUNTRY?		<u>U.S.A.</u>			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		ADDRESS <u>same</u>	
<u>E.D. Privett</u>		<u>Unknown</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
<u>NO</u>		<u>245-03-3951</u>		<u>Eddie Privett, Jr. (son)</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
<u>250.01</u>		<u>Cerebral Thrombosis</u>		<u>30 hours</u>	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE			
ANTECEDENT CAUSES		DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Generalized Arteriosclerosis</u>		<u>Unknown</u>	
		(C) <u>Diabetes mellitus with Acidosis</u>		<u>Unknown</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
<u>None</u>				<u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE OIO INJURY OCCURRED (If in Baltimore City, give exact location)	
<u>no</u>					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <u>7/25</u> 19 <u>72</u> to <u>9/29</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>9/29</u> 19 <u>72</u> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
<u>D. W. Stewart, M.D.</u>				<u>9/29/72</u>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
<u>D. W. STEWART, M.D.</u>		<u>2300 Garrison Blvd.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
<u>Burial</u>		<u>10/4/72</u>		<u>Baeternase</u>	
24D. LOCATION (City, town, or county)		24E. FUNERAL DIRECTOR		24F. ADDRESS	
<u>Baeternase</u>		<u>W. J. Phillips</u>		<u>1727 N. Mount</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
<u>OCT 3 1972</u>		<u>W. J. Phillips</u>		<u>W. J. Phillips</u>	



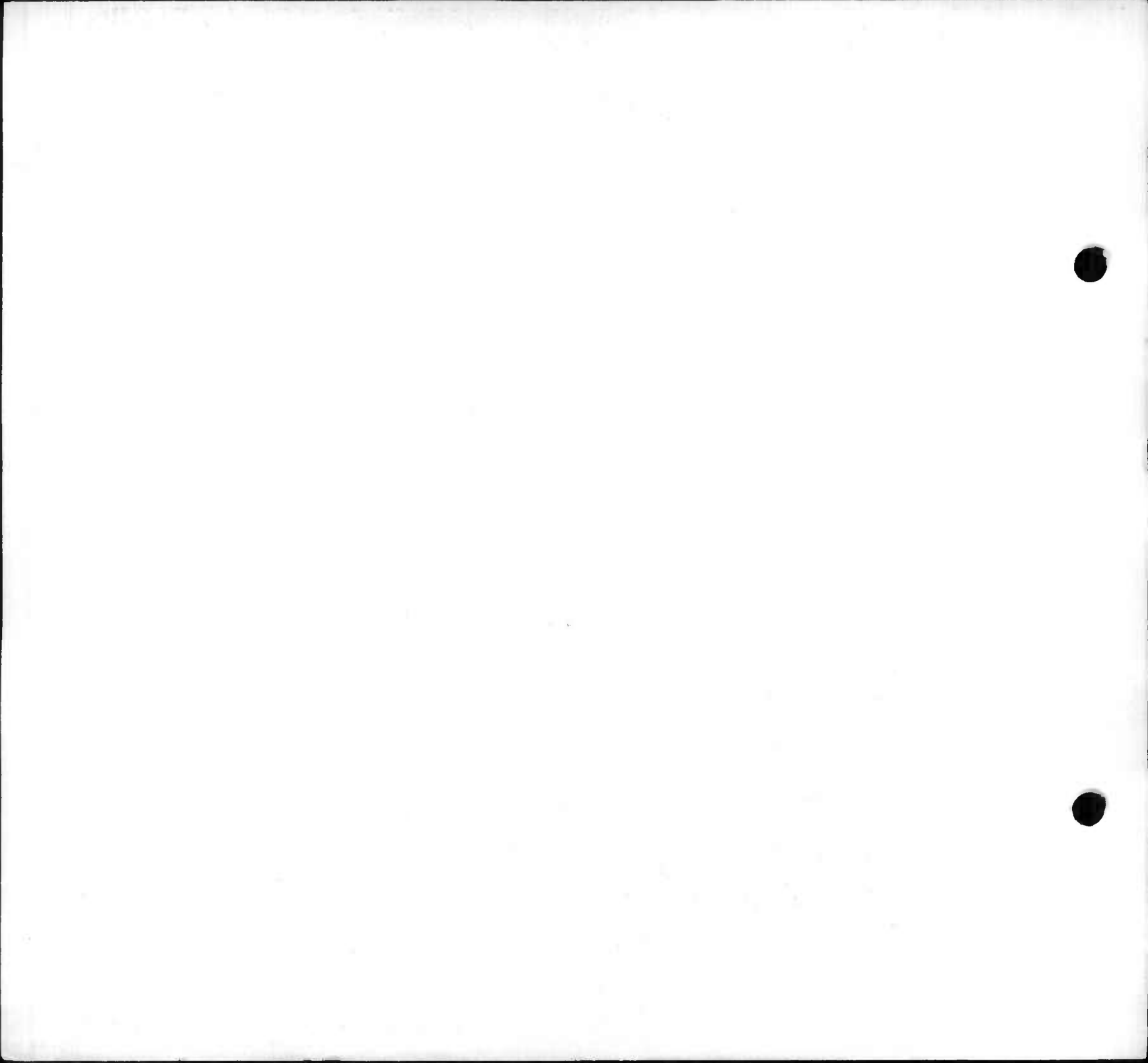
C-600		72 09427		STATE OF MARYLAND-DHMH BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 72 09427	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		3. DATE PRONOUNCED DEAD		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
		Ruth Helen Carey		Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 9 28 72 6:00 P.M.		Month Day Year Hour 9 28 72 6:00 P.M.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)	
								Johns Hopkins Hospital	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		A. STATE		B. COUNTY		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
Maryland		806				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX		7. RACE		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. DATE OF BIRTH		10. AGE (In years last birthday)	
Female		Negro		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5-23-1925		47	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME	
Charlottesville, VA.				Martin Howard		Housewife		Estelle Carter	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT		19. 57181		CAUSE OF DEATH	
				Walter Carey				DISEASE OR CONDITION DIRECTLY LEADING TO DEATH	
				Virginia				(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)	
								(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
								Fatty metamorphosis of liver	
								(B) DUE TO, OR AS A CONSEQUENCE OF:	
								(C) DUE TO, OR AS A CONSEQUENCE OF:	
								OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
2				Yes				22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED		22F. HOW DID INJURY OCCUR?		23.			
(APPROX.)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
						ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
						W P Mulloy M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
						EXAMINER'S NAME (Type)		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
						William P. Mulloy M.D.		DATE SIGNED	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)		9-29-72	
Removal		9/30/72		Oakwood		Charlottesville VA.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
OCT 3 1972		A. J. H. H. H.		W. L. H. H. H.		1727 N. Monroe St.			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-150		72 09428		BALTIMORE CITY HEALTH DEPARTMENT		72 09428	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO. 27-92-88		STATE OF MARYLAND-DEME	
1. NAME OF DECEASED (Type or Print) <i>Ruffin, Shirley Thelma</i>				2. DATE AND HOUR OF DEATH <i>Oct 2 - 1972 12<sup>05</sup> A.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>University of Maryland</i>				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1603</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>1720 Harlem Avenue 21223</i>			
5. SEX <i>F</i>	6. RACE <i>N</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-24-32</i>	9. AGE (In years last birthday) <i>40</i>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>at Home</i>		11. BIRTHPLACE (State or foreign country) <i>MD</i>	
12. CITIZEN OF WHAT COUNTRY? <i>US</i>							
13. FATHER'S NAME <i>Ruffin, Joseph Henry</i>				14. MOTHER'S MAIDEN NAME <i>Johnson, Forence</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Florence Thomas 127 N. Schroeder St</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Branchogenic Carcinoma, Metastatic</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>13 DAYS</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <i>1-9-24-72</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Brain Tumor</i>		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from <i>18 Sept 1972</i> to <i>2 Oct 1972</i> that (we) lost saw the deceased alive on <i>2 Oct 1972</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Walker Robinson, MD</i>				23B. DATE SIGNED <i>2 Oct 72</i>			
23C. PHYSICIAN'S NAME (Type) <i>Walker Robinson, MD</i>				23D. ADDRESS <i>University Hospital Balt. Md.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>10/5/72</i>		24C. NAME OF CEMETERY or CREMATORY <i>Wt Auburn</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 4 1972</i>		25B. NAME OF REGISTRAR <i>Sidney Weston</i>		25C. FUNERAL DIRECTOR <i>Wm. H. Smith</i>		ADDRESS <i>638 N. J. Ave</i>	

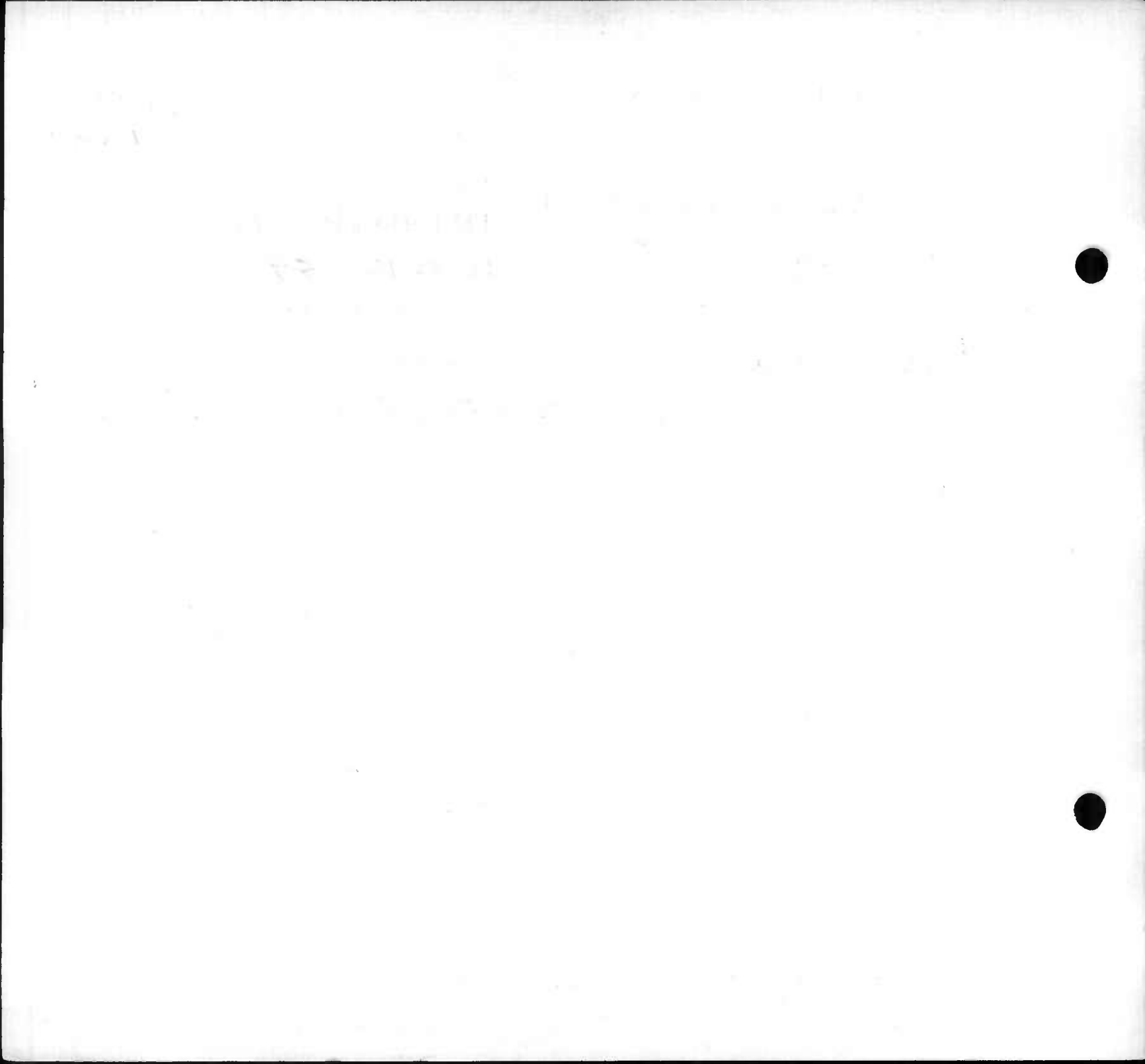




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-152		72 09429		BALTIMORE CITY HEALTH DEPARTMENT		72 09429	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) Walker Evans				2. DATE AND HOUR OF DEATH 10-3-72 7 <sup>20</sup> am M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 1603			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 Lutheran Hospital 730 Ashburton St				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M		6. RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-25-12	
9. AGE (In years last birthday) 259		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY ASPHALT		11. BIRTHPLACE (State or foreign country) CHESTER S.C.	
13. FATHER'S NAME SAMUEL EVANS				14. MOTHER'S MAIDEN NAME JALBY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. 240-03-4333		17. INFORMATION ADDRESS RUBY EVANS HIGH PR. N.C.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) TERMINAL CA, Lung				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH -			
18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 9/30 1972 to 9/29 1972 that (I) (we) last saw the deceased alive on 10/3 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Rufino Montenegro M.D.				23B. DATE SIGNED 10/3/72			
23C. PHYSICIAN'S NAME (Type) RUFINO MONTENEGRO M.D.				23D. ADDRESS 730 ASHBURTON ST. BALTO. MD.			
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE 10/9/72		24C. NAME OF CEMETERY OR CREMATORY MT AUBURN		24D. LOCATION (City, town, or county) (State) BALTO MD	
25A. DATE REC'D BY HEALTH DEPT. OCT 4 1972		25B. NAME OF REGISTRAR Audrey H. [unclear]		25C. FUNERAL DIRECTOR [unclear]		ADDRESS [unclear]	



72 09430

STATE OF MARYLAND - DHMH  
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 09430

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

PERCY CARMEL

2. DATE  
OF DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

September 28, 1972

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Provident Hospital (DOA)

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

September 28, 1972 8:05 A

M.

5. USUAL RESIDENCE (Where deceased lived, if Institution; residence before admission)

A. STATE

B. COUNTY

Maryland

15-11

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

10. AGE (In years  
last birthday)

72 XX

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

3320 Barrington Road

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

ABRAHAM S. CARMEL

14. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

SALESMAN

14B. KIND OF BUSINESS OR INDUSTRY

RETAIL

15. MOTHER'S MAIDEN NAME

MARY LEE SMITH

16. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no or unknown) (If yes, give war or dates of service)

YES

W.W. II ARMY

17. SOCIAL  
SECURITY NO.

218-22-5054

18. INFORMANT

ADDRESS

MRS. HATTIE FREED, 3320 BARRINGTON RD. #21218

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Subarachnoid hemorrhage  
DUE TO, OR AS A CONSEQUENCE OF:

Rupture of aneurysm of circle of Willis

(B) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF:

(C) \_\_\_\_\_

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)22E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐Deputy CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Ronald N. Kornblum, M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

September 28, 1972

24A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

10/2/1972

24C. NAME of CEMETERY or CREMATORY

ADATH YESHURUN (SODOVA)

24D. LOCATION (City, town, or county)

(State)

BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.

OCT 4 1972

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

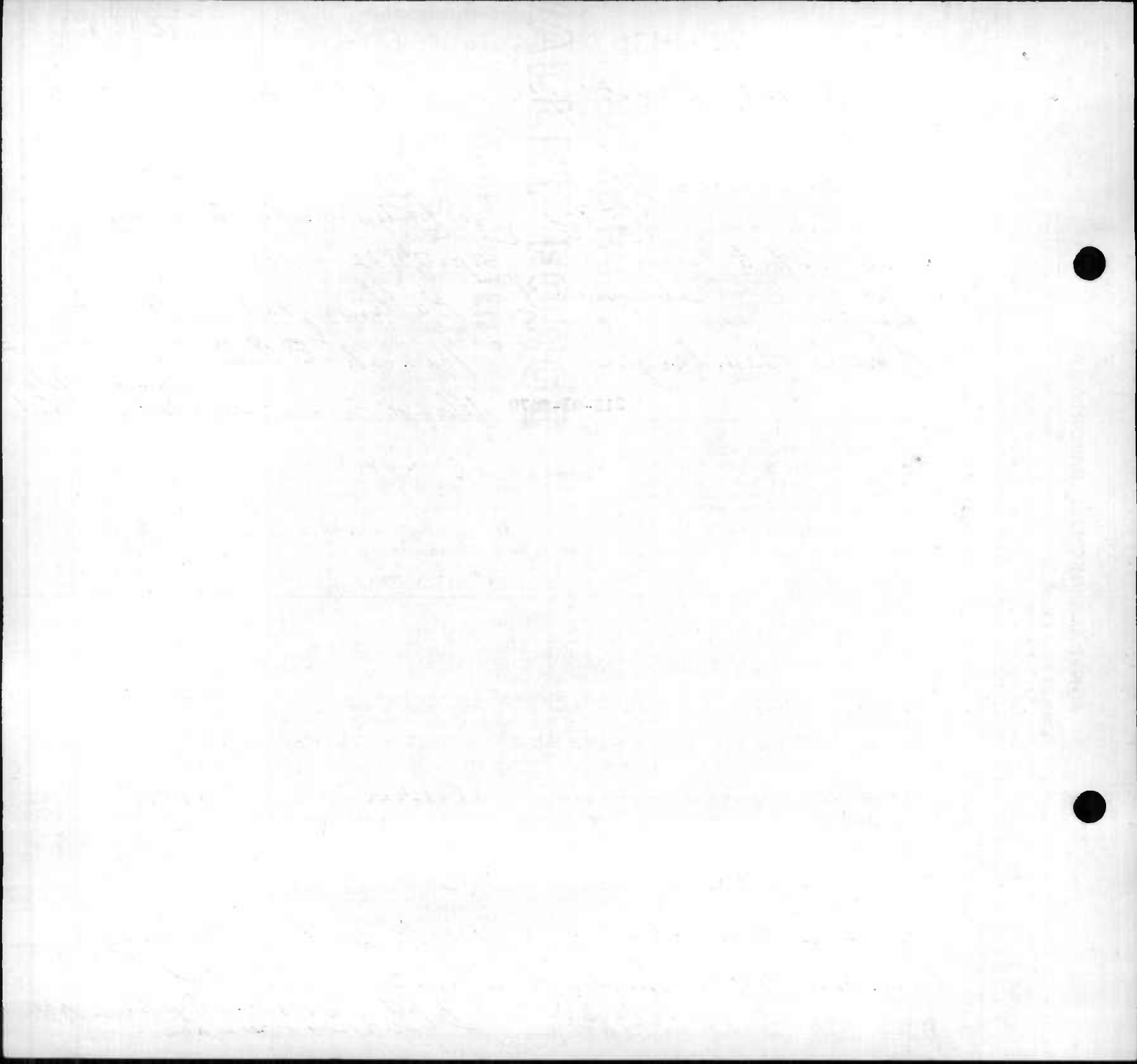
SQU LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	72 09431
BIRTH NO. <b>B-516</b>		72 09431		STATE OF MARYLAND-DMH	
1. NAME OF DECEASED (Type or Print) <b>Jennie Bamberger</b>		2. DATE AND HOUR OF DEATH <b>Sept 30/72</b> <b>4 58</b> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Ind.</b> B. COUNTY <b>1307</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>500 W. University Parkway.</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>500 W. University Parkway.</b>					
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr 7, 1872</b>	9. AGE in years (last birthday) <b>100</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Buyer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Schoen-Russell Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Ind.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Ansel Bamberger</b>		14. MOTHER'S MAIDEN NAME <b>Hannah Elean</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-03-8670</b>		17. INFORMANT <b>Allan H. Fisher - 2307 Ind National</b>	
18. <b>41211</b>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>C. V. D.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Branches Pneumonia</b>		<b>3 days</b>	
		(C) <b>H. A. S. H. D.</b>		<b>3 years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>7/7/1969</b> 19 to <b>9/30</b> 19 <b>72</b> , that (I) (we) lost saw the deceased alive on <b>9/30/72</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Isaiah Zinberg</b>		23B. DATE SIGNED <b>10/1/72</b>		23C. PHYSICIAN'S NAME (Type) <b>ISRAEL ZINBERG</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		24B. DATE <b>10/2/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Louder Park Crematory</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto, Ind.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 4 1972</b>		25B. NAME OF REGISTRAR <b>Adrian H. Hinton</b>	
25C. FUNERAL DIRECTOR <b>Pol Turner</b>		25D. ADDRESS <b>6010 Reisterstown Rd.</b>			

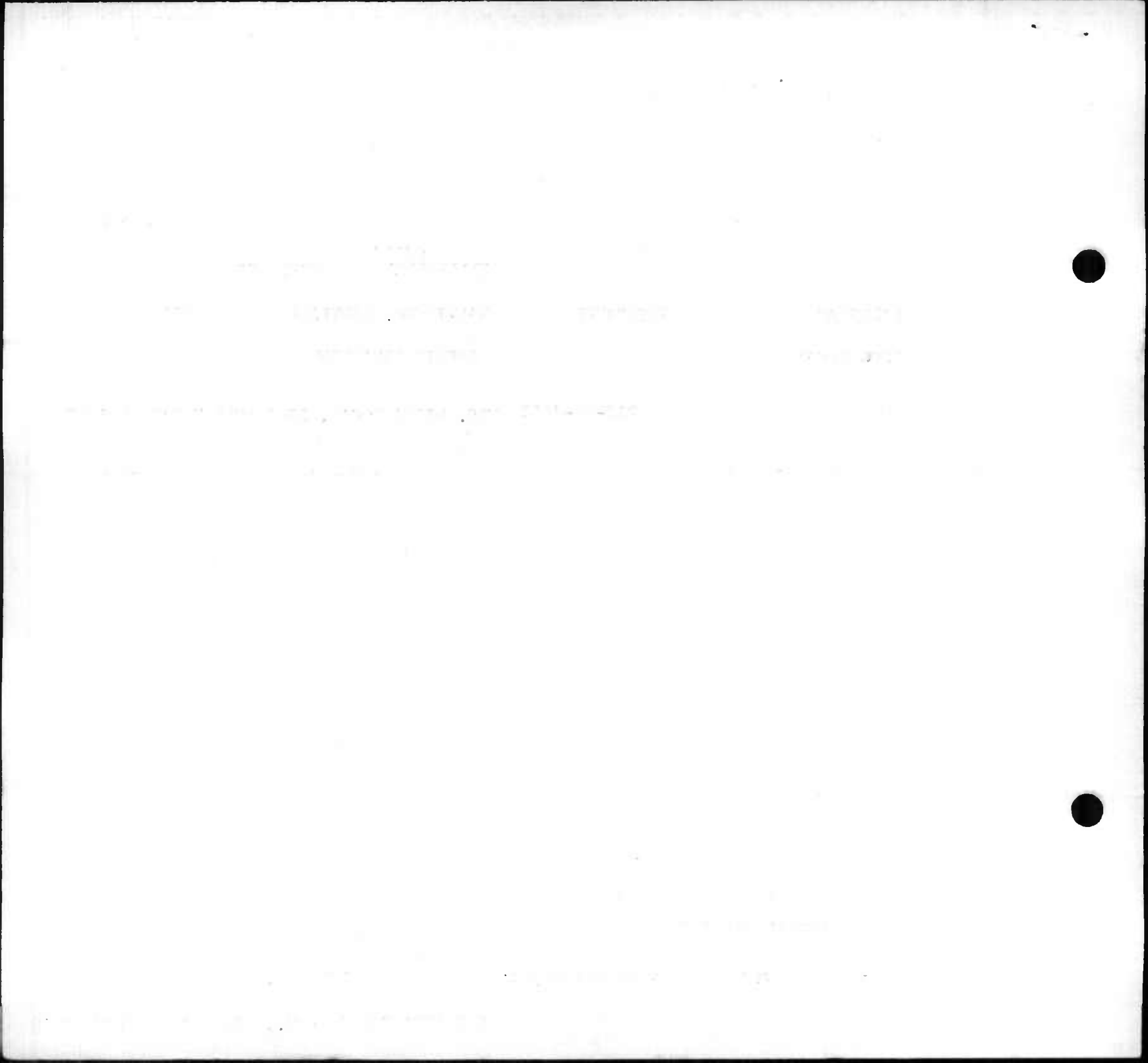


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>B-230</b> <span style="float: right;">72 09432</span></p> <p style="text-align: center;">BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. <b>72 09432</b> STATE OF MARYLAND - DEHE</p>	
<p>BIRTH NO. <b>1</b></p>		<p>1. NAME OF DECEASED (Type or Print) <b>SOL A. BOGAT</b></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>		<p>2. DATE AND HOUR OF DEATH <b>9/29/72 12:45</b> <span style="float: right;">A M.</span></p>	
<p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Sina Hospital, Inc. Belvedere Ave Green Spring Ave. Baltimore, Maryland, 21215</b></p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3702 Durley Lane 21207</b></p>	
<p>5. SEX <b>Male</b></p>	<p>6. RACE <b>White</b></p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <b>5/18/95</b> 9. AGE (In years last birthday) <b>77</b> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b></p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY <b>INSURANCE</b></p>	
<p>11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b></p>		<p>12. CITIZEN OF WHAT COUNTRY? <b>USA</b></p>	
<p>13. FATHER'S NAME <b>LEON BOGAT</b></p>		<p>14. MOTHER'S MAIDEN NAME <b>SOPHIE LIVITESKY</b></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <b>NO</b></p>		<p>16. SOCIAL SECURITY NO. <b>212-09-4415</b></p>	
<p>17. INFORMANT <b>MRS. HILDA BOGAT, 3702 DURLEY LANE #21207</b></p>		<p>ADDRESS</p>	
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>Coronary Vascular Disease</b> <b>Respiratory</b> <b>Accident</b> <b>CVA</b></p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Hypertension</b> <b>Probable</b></p>	
<p>(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Probable Myocardial Infarction</b></p>		<p>(C)</p>	
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION <b>0</b></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No) <b>NO</b></p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (1) (this hospital) attended the deceased from <b>August 1</b> 19 <b>72</b> to <b>September 29</b> 19 <b>72</b> that (1) (we) lost saw the deceased alive on <b>September 29</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <b>Robert Kroopnick, M.D.</b></p>		<p>23B. DATE SIGNED <b>9/29/72</b></p>	
<p>23C. PHYSICIAN'S NAME (Type) <b>ROBERT KROOPNICK</b></p>		<p>23D. ADDRESS <b>9008 Meadow Heights Road Pikesville, Maryland</b></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b></p>		<p>24B. DATE <b>10/1/72</b></p>	
<p>24C. NAME OF CEMETERY OR CREMATORY <b>HEBREW FRIENDSHIP</b></p>		<p>24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <b>OCT 4 1972</b></p>		<p>25B. NAME OF REGISTRAR <b>Edwin J. ...</b></p>	
<p>25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS.</b></p>		<p>ADDRESS <b>6010 REISTERSTOWN ROAD</b></p>	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09433	
CERTIFICATE OF DEATH				REG. NO.	
BIRTH NO. <b>7-655</b>		1. NAME OF DECEASED (Type or Print) <b>PAUL MARTIN FREYMAN</b>		2. DATE AND HOUR <b>SEPTEMBER 30, 1972</b> <b>5<sup>35</sup></b> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSPITAL</b> (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2720</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>6210 PARK HEIGHTS AVENUE, APT. 205</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 31, 1904</b>	9. AGE (In years last birthday) <b>68</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BUYER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>FOREIGN</b>		11. BIRTHPLACE (State or foreign country) <b>GERMANY</b>	
13. FATHER'S NAME <b>DR. ADLOPH FREYMAN</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>059-14-8284A</b>		17. INFORMANT ADDRESS <b>MRS. ANNE FREYMAN, 6210 PK. HGHTS. AVE., APT. 205</b>	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CORONARY OCCLUSION</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Coronary arteriosclerotic heart dis.</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CORONARY OCCLUSION</b> (B) <b>Coronary arteriosclerotic heart dis.</b> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 Hour</b> <b>12 years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>Feb. 3</b> <b>1972</b> to <b>Sept. 30, 1972</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>Sept. 27</b> <b>1972</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>was</del> ) ( <del>did</del> ) (did not) view the body after death.					
23A. SIGNATURE <b>Abraham B. Hurwitz MD</b>				23B. DATE SIGNED <b>Sept. 30, 1972</b>	
23C. PHYSICIAN'S NAME (Type) <b>ABRAHAM HURWITZ</b>		23D. ADDRESS <b>7501 LIBERTY ROAD</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10/1/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>BALTIMORE HEBREW</b>	
24D. LOCATION (City, town, or county) <b>BALTIMORE, MARYLAND</b>		24E. LOCATION (State) _____			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 4 1972</b>		25B. NAME OF REGISTRAR <b>Aditya Indur...</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SQL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09434	
R-246 72 09434				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Rochberg Robert A.		9-29-72 3:30 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland General Hospital, 827-Linden Avenue, Baltimore, Md. 21201.				A. STATE Maryland, USA C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX MALE				6. RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 12/30/50	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)	
STUDENT				Baltimore, Maryland	
10B. KIND OF BUSINESS OR INDUSTRY SCHOOL				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DR. Samuel Rochberg				14. MOTHER'S MAIDEN NAME TOBA KLEIMAN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 2 19-50-9091	
17. INFORMANT DR. SAMUEL ROCHBERG, 2202 W. ROGERS AVE. #21209				ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Respiratory Failure 4 yrs.	
19. DATE OF OPERATION 2				20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
22. I certify that (I) (this hospital) attended the deceased from 9-22-1972 to 9-29-1972 that (I) (we) last saw the deceased alive on 9-29-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23B. DATE SIGNED 9-29-72	
23A. SIGNATURE Mushlag Ahmed M.D.				23C. PHYSICIAN'S NAME (Type) Mushlag Ahmed M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 10/2/72	
24C. NAME of CEMETERY or CREMATORY CHIZUK AMUNO (ARL(INGTON))				24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. OCT 4 1972				25B. NAME OF REGISTRAR SOB LEVINSON & BROS., 6010 REISTERSTOWN ROAD	

30  
BATTALION  
TOMAS LELAND

ROAD

WEST

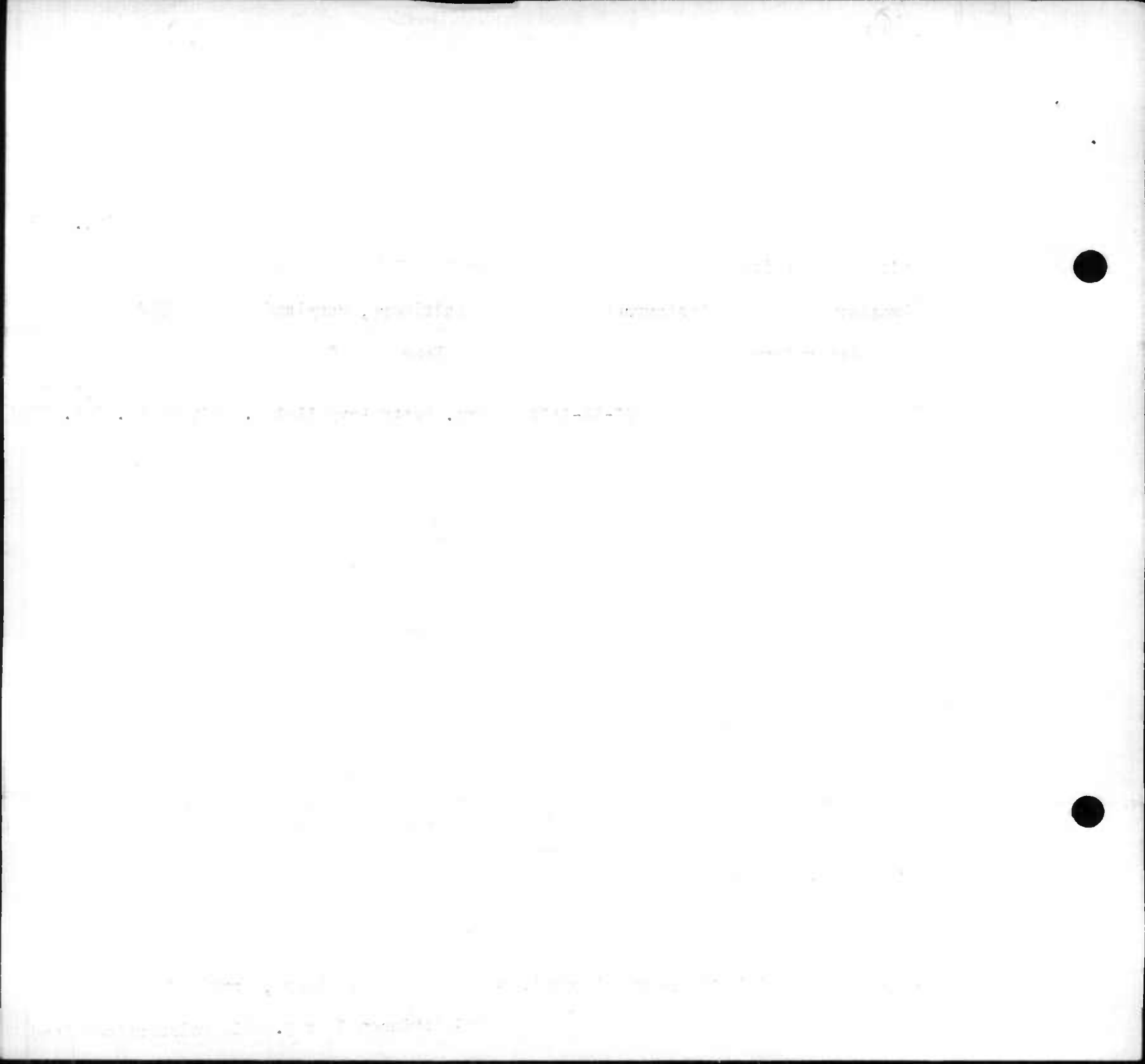
STREET

DR. JAMES B. BROWN

10-2-20

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-100		72 09435		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09435	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MORRIS LEVY				2. DATE AND HOUR OF DEATH 9-30-72 10:10 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) LUTHERAN HOSPITAL OF MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY MARYLAND 1101			
				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1101 N. CALVERT STREET Apt. 1804			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-10-10	9. AGE (In years last birthday) 62	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10B. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Meyer Levy				14. MOTHER'S MAIDEN NAME Tema ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-12-8871		17. INFORMANT ADDRESS Mrs. Betty Levy 1101 N. Calvert St. Apt. 1804			
18. CAUSE OF DEATH							
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary Embolism		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 hours	
				(B) Acute Intestinal Obstruction		17 days.	
				(C) Carcinoma Colon Grade III		?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 9-14-72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED INTESTINAL OBSTRUCTION due to Car. Colon		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? -	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) -		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -			
22. I certify that (1) (this hospital) attended the deceased from 9-13-1972 to 9-30-1972 that (1) (we) last saw the deceased alive on 9-30-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE M. A. AMWAR				23B. DATE SIGNED 9-30-72		23C. PHYSICIAN'S NAME (Type) M. A. AMWAR	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/2/1972		24C. NAME of CEMETERY or CREMATORY Hebrew Young Mens		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. OCT 4 1972		25B. NAME OF REGISTRAR Sol Levinson		25C. FUNERAL DIRECTOR Sol Levinson & Bros.		ADDRESS 6010 Reisterstown Road	

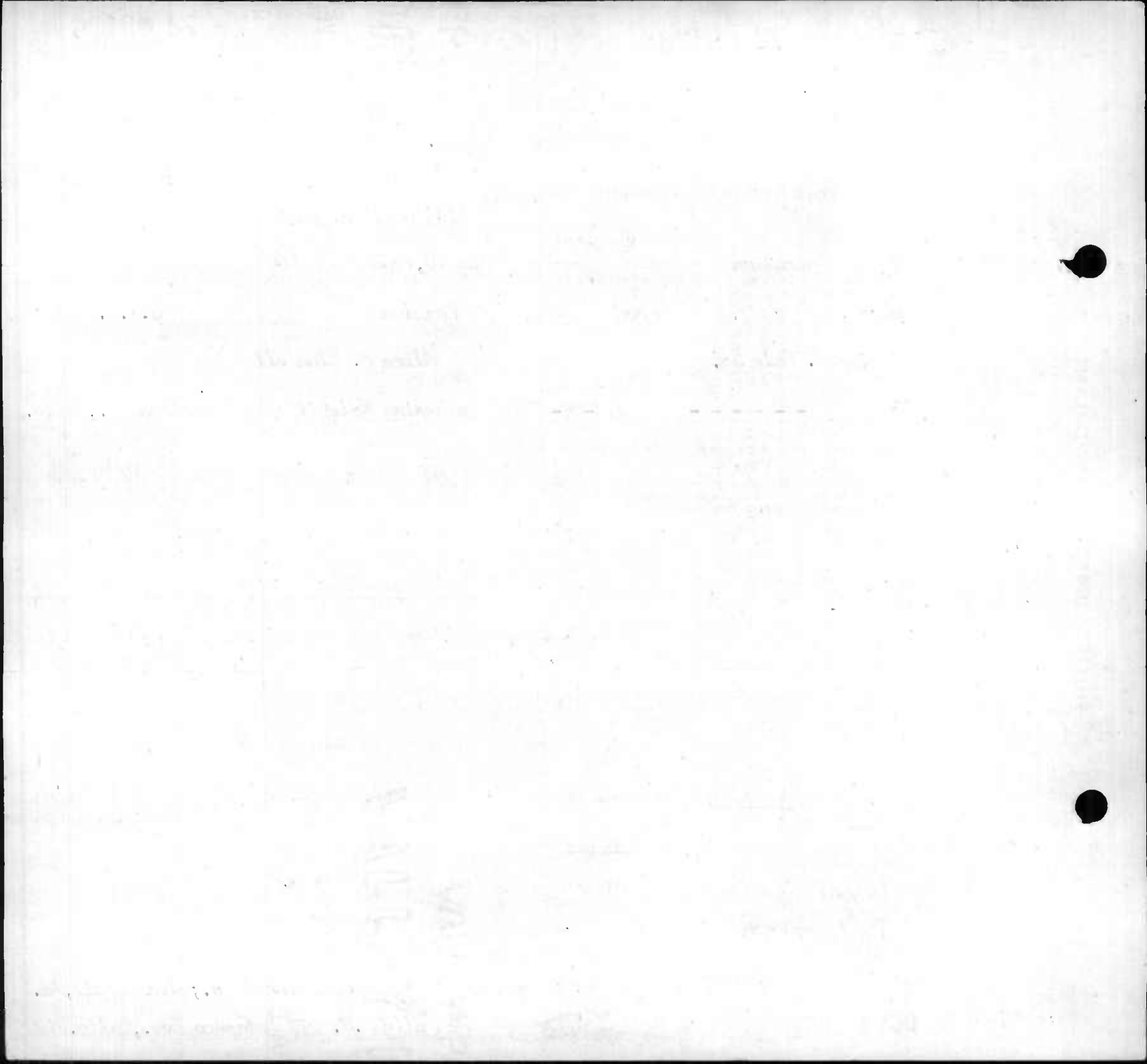




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

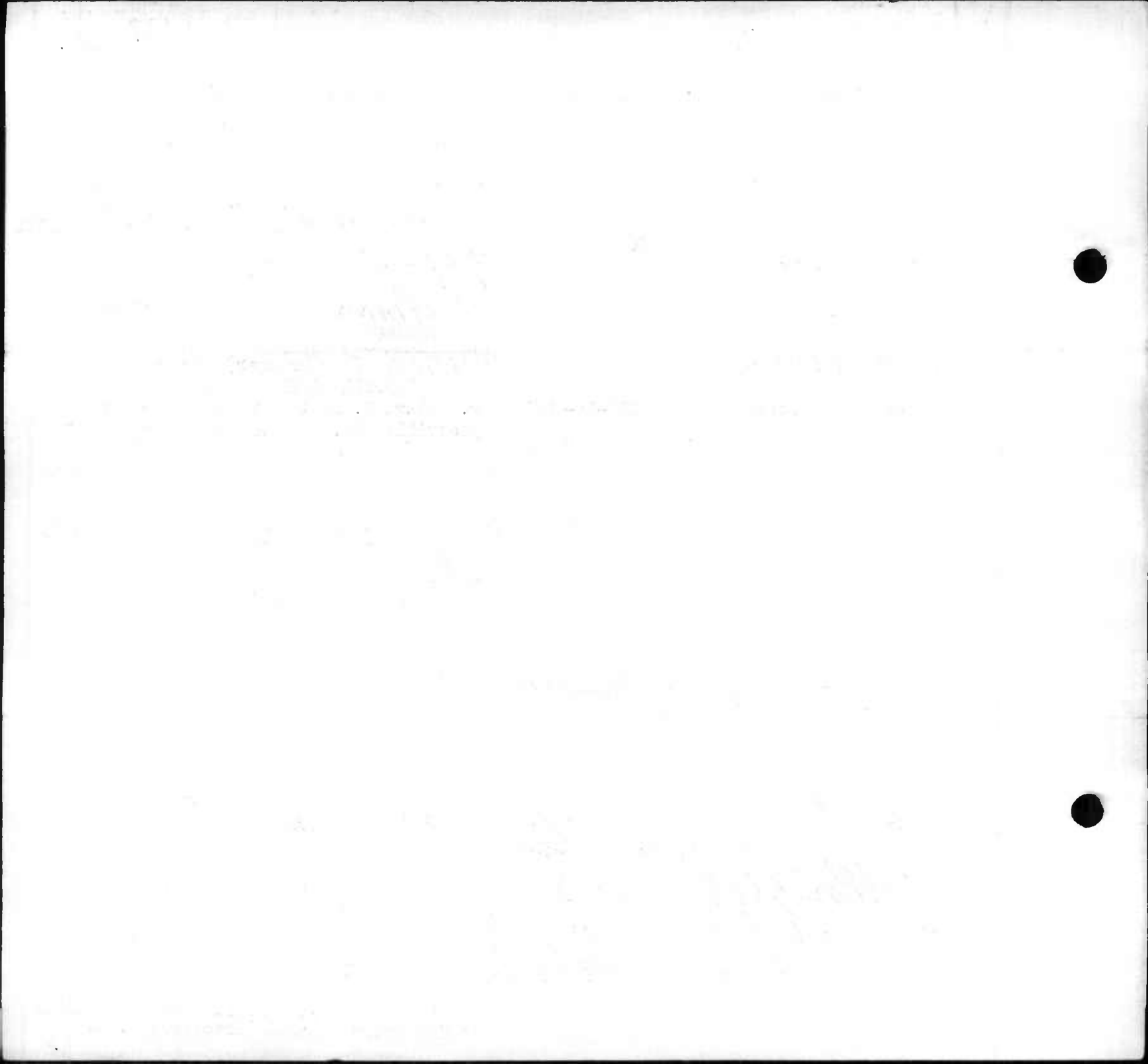
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 09436</b>	
CERTIFICATE OF DEATH				STATE OF MARYLAND - DEATH	
BIRTH NO. <b>4-400</b>		72 09436			
1. NAME OF DECEASED (Type or Print) <b>WILLIAM HALE, JR.</b>			2. DATE AND HOUR OF DEATH <b>9/30/72 1:30 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SOUTH BALTIMORE GENERAL HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>2505</b>		
			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>4133 Mariban Court</b>		
5. SEX <b>Male</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 10, 1906</b>	9. AGE (In years last birthday) <b>66</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Baker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Food</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>William W. Hale Sr.</b>			14. MOTHER'S MAIDEN NAME <b>Alice B. Blundell</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-09-6707A</b>		17. INFORMANT ADDRESS <b>Catherine Hale (Wife) 4133 Mariban Ct., Balto. 21225</b>	
18. <b>497X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CHRONIC BRONCHITIS AND EMPHYSEMA</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Generalized arteriosclerosis, severe</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Pulmonary edema</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 + YRS.</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>CORONARY INSUFFICIENCY</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 + YRS.</b>		
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO</b>		(If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/29 1972</b> to <b>9/32 1972</b> , that (I) (we) last saw the deceased alive on <b>9/30 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Robert J. Bauer, M.D.</b>				23B. DATE SIGNED <b>9/30/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>ROBERT J. BAUER, M.D.</b>				23D. ADDRESS <b>3001 S. HANOVER ST. BALTIMORE, MD.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/3/1972</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cemetery</b>	
24D. LOCATION <b>Anne Arundel Co.; Glen Burnie, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 4 1972</b>		25B. NAME OF REGISTRAR <b>Sidney [Signature]</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Mc Cully F.H. 237 Patapsco Ave., Balto. 21225</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09437		REG. NO. 72 09437	
B-000				STATE OF MARYLAND - DISTRICT			
1. NAME OF DECEASED (Type or Print) <b>KATHRYN L. Bowie</b>				2. DATE AND HOUR OF DEATH <b>1 October 72 1110 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNIVERSITY Hospital</b> <b>38</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> 8. COUNTY <b>Carroll</b> C. CITY OR TOWN <b>Sykesville</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>Route No. 4 Box 344</b> <b>Carroll Highlands Rd</b> 21784			
5. SEX <b>F</b>	6. RACE <b>CAU</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/3/25</b>		9. AGE (In years last birthday) <b>47</b>	10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>JOHN FRANK</b>			
14. MOTHER'S MAIDEN NAME <b>Margaret (Granger) Frank</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b> <b>None</b>			
16. SOCIAL SECURITY NO. <b>219-18-4061</b>				17. INFORMANT <b>Carroll Highlands Road</b> ADDRESS <b>Mr. Robert I. Bowie Route 4 Box 344</b>			
18. <b>430.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CONGESTIVE EDEMA</b>				CAUSE OF DEATH <b>Sykesville, Md.</b> 21784		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>38 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Rupt Aneurysm (R) Mid Cerebral</b>		<b>10 days</b>	
(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Battery</b>				(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>9/28/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Ruptured Aneurysm</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from <b>9/21/72</b> 1972 to <b>10/1/72</b> 1972 that (we) lost saw the deceased alive on <b>10/1/72</b> 1972 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death.							
23A. SIGNATURE <b>Walter L. Robinson, M.D.</b>				23B. DATE SIGNED <b>10/1/72</b>		23C. PHYSICIAN'S NAME (Type) <b>Walter L. Robinson M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10/4/1972</b>		24C. NAME OF CEMETERY or CREMATORY <b>LAKE VIEW MEMORIAL PARK</b>		24D. LOCATION (City, town or county) (State) <b>SYKESVILLE CARROLL MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 4 1972</b>				25B. NAME OF REGISTRAR <b>Loring Byers</b>		25C. FUNERAL DIRECTOR <b>8728 Liberty Road ADDRESS 21133</b> <b>Loring Byers Funeral Directors, P. A.</b>	



61-56-61

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-536		72 09438		CITY HEALTH DEPARTMENT		REG. NO. <u>72 09438</u>	
BIRTH NO.		NAME OF DECEASED		DATE AND HOUR OF DEATH		STATE OF MARYLAND - DECEASED	
		Carole Ann Snyder		9/30/72		3:02 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION				A. STATE B. COUNTY			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				Maryland Baltimore			
4940 Eastern Avenue, Baltimore, Md. 21224				C. CITY OR TOWN Edgemere		D. INSIDE CITY LIMITS?	
Baltimore City Hospitals				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER				3113 Whiteway Road			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. Under 1 Yr. Months: Days:	11. Under 24 Hrs. Hours: Min.	12. CITIZEN OF WHAT COUNTRY?
Female	Caucasian	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8/19/46	26			U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Key punch Operator		Beth. Steel Co.		Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Charles H. Snyder				Marie J. Notaro			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT			
No		214-50-4647		4940 Eastern Avenue ADDRESS			
				BCH RECORDS: Baltimore, Maryland 21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
2.05.01							
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE			
ANTECEDENT CAUSES				CVA			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO, OR AS A CONSEQUENCE OF:			
				(B) Bone Marrow Transplant			
				DUE TO, OR AS A CONSEQUENCE OF:			
				(C) Acute Myelogenous Leukemia			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (this hospital) attended the deceased from July 26, 1972 to September 29, 1972 that (we) last saw the deceased alive on September 29, 1972 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Roland C. Einhorn, MD				9/30/72			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		23E. FUNDING DIRECTOR		ADDRESS	
Roland Einhorn		Baltimore City Hospitals		John J. Duda		17922 Wise Ave. Dundalk, Md. 21222	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		10-3-72		Lorraine Park Mausoleum		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNDING DIRECTOR		ADDRESS	
OCT 4 1972		Andrey W. Kozlov		John J. Duda		17922 Wise Ave. Dundalk, Md. 21222	

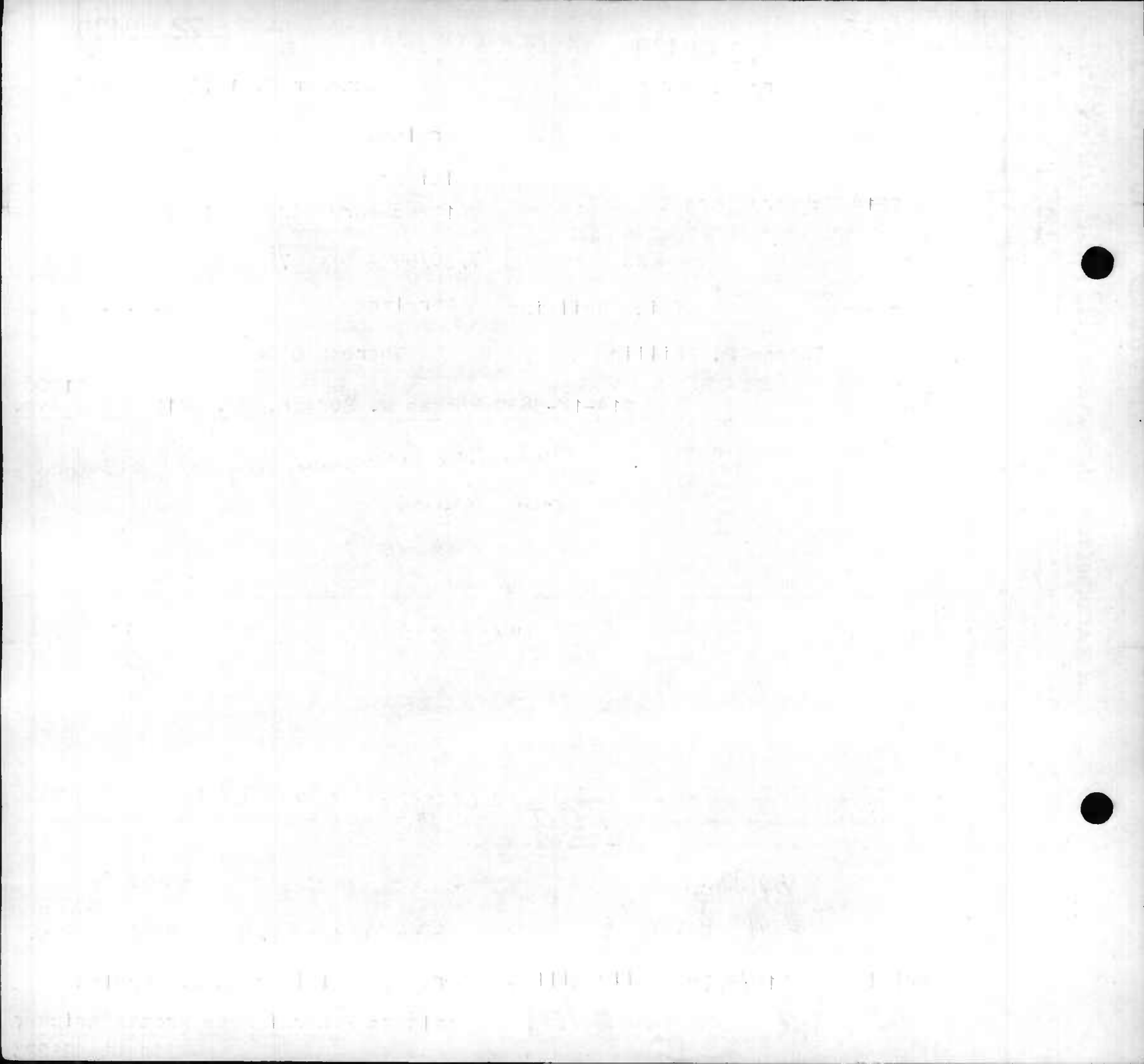


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72-09430	
BIRTH NO. 72 09439				STATE OF MARYLAND - DEPT.	
1. NAME OF DECEASED (Type or Print) Mary L. Burgan			2. DATE AND HOUR OF DEATH October 2, 1972 4:45 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2014 McHenry Street			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2014 McHenry Street 21223		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/30/94	9. AGE (In years last birthday) 78	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Charwoman		10B. KIND OF BUSINESS OR INDUSTRY Office Building		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Thomas R. Phillip		
14. MOTHER'S MAIDEN NAME Theresa O'Day			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 214-18-5832			17. INFORMANT ADDRESS 21206 Thomas R. Burgan, Sr. 4312 Raspe Ave.		
18. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Metastatic Carcinoma, lungs and brain (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: malnutrition		
19A. DATE OF OPERATION 1972			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 4 weeks		
20A. AUTOPSY? (Yes or No) No			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 12 Aug 1972 to Oct 1972, that (I) (we) last saw the deceased alive on 1 Oct 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE H. H. Baylus			23B. DATE SIGNED 2 Oct 72		
23C. PHYSICIAN'S NAME (Type) H. H. BAYLUS			23D. ADDRESS 1600 WILKENS AVE BALTO., MD.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/5/72		24C. NAME OF CEMETERY or CREMATORY Holly Hill Cemetery	
24D. LOCATION Baltimore Co., Maryland		25A. DATE REC'D BY HEALTH DEPT. OCT 4 1972			
25B. NAME OF REGISTRAR L. J. H. H. H.		25C. FUNERAL DIRECTOR Walters Funeral Home Pratt & Stricker			
25D. ADDRESS Streets 21223					





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-626		72 09440		BALTIMORE CITY HEALTH DEPARTMENT		72 09440	
BIRTH NO.		72 09440		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)		IRENE FRANCES GREGOREK		2. DATE AND HOUR OF DEATH		10.2.72 1:35 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		MARYLAND		2745	
37		MERCY HOSPITAL 301 ST. PAUL PLACE		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER		6511 BROOK ROAD	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months: Days	11. Under 24 Hrs. Hours: Min.	12. CITIZEN OF WHAT COUNTRY?
F	W	WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9.21.26	46			U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
HOUSEWIFE				BALTIMORE		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
WALLACE MALANOWSKI		FRANCES C JACHOWSKI		NO		216-20-5235	
17. INFORMANT		ADDRESS		18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
MICHAEL E. GREGOREK		6511 BROOK AVE		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			
				(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)			
				ANTECEDENT CAUSES			
				DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
WILLIAM DAVIDSON				10/2/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
				301 ST PAUL PLACE			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		OCT 5/72		HOLY ROSARY CEM.		GERMANY HILL RD MD	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
OCT 4 1972		Anthony [Signature]		Dipha Brothers		7110 Bair Rd	

20-10-32

10

WILLIAM BRIDSON

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <u>278 09441</u>	
I-524		72 09441		STATE OF MARYLAND-DEM			
1. NAME OF DECEASED (Type or Print)		ALMA INSLEY		2. DATE AND HOUR OF DEATH		10/1/1972	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>90 Bolton Hill Nursing Home</u>				A. STATE Maryland			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) Bolton Hill Nursing Home			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.
Female	Caucasin	Widow	10/2/1893	78			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Practical Nurse			Maryland		U. S. A.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME				
L. J. Murray			Alice ? ? ?				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
No.			220 22 5061		Alma Rose Carr 2128 Fleet St.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES			C.V.A. chronic brain syndrome			several days.	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO			several months	
			(B) DUE TO			cerebro-vascular arteriosclerosis several yrs.	
			(C) DUE TO				
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>3-30</u> 19 <u>72</u> to <u>10-1-</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>9-28</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>E. Ellsworth Cook</u>						23B. DATE SIGNED <u>10-2-72</u>	
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS	
E. ELLSWORTH COOK						2431 MARYLAND AVE. BALTO Md. 21218	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		10/3/72		Meadowridge Cemetery		Dorsey Howard County, Md.	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 4 1972</u>				25B. NAME OF REGISTRAR <u>Raymond P. Fink</u>			
				25C. FUNERAL DIRECTOR ADDRESS <u>Glen Burnie, Md.</u>			

~~Bolton Hill to Return call~~

3/30/72 -Adm

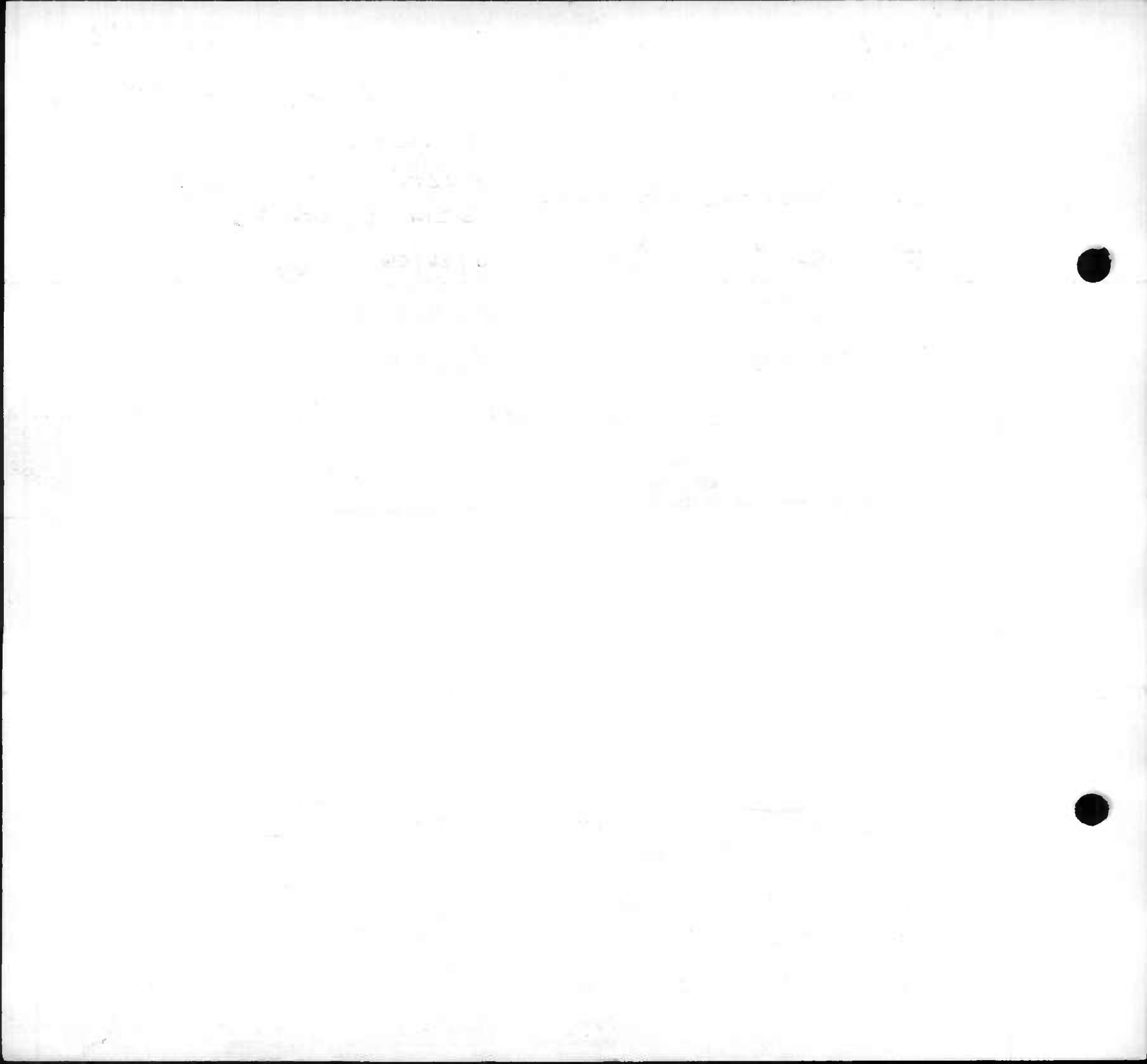
Prev. address also N. H

Coded to Lafayette + John sts.

# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09442	
A-654 72 09442		STATE OF MARYLAND-DEATH	
1. NAME OF DECEASED (Type or Print) <b>ROSE ARNOLD</b>		2. DATE AND HOUR OF DEATH <b>29 Sept 1972 9:15 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SINAI HOSPITAL OF BALTIMORE</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2738</b>	
		C. CITY OR TOWN <b>BALTIMORE</b>	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <b>6214 Falkirk Rd</b>	
5. SEX <b>F</b>	6. RACE <b>C W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/26/06</b>
		9. AGE (In years last birthday) <b>66</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>JOHN CONRAD</b>		14. MOTHER'S MAIDEN NAME <b>ANNA KING</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service] <b>NO</b>		16. SOCIAL SECURITY NO. <b>212-16-6520</b>	17. INFORMANT <b>MRS. FLORENCE Lipinski</b>
		ADDRESS <b>6214 FALKIRK RD</b>	
18. <b>153.81</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Carcinomatosis</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) <b>Carcinoma of colon + ovary</b> DUE TO, OR AS A CONSEQUENCE OF:  (C) _____	
		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>2</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>yes</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/26</b> 19 <b>72</b> to <b>9/29</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>9/29</b> 19 <b>72</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Karen M. Lichtenfeld MD</b>		23B. DATE SIGNED <b>9/29/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Karen M. Lichtenfeld MD</b>		23D. ADDRESS <b>SINAI HOSP.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>10/3/72</b>	24C. NAME OF CEMETERY OR CREMATORY <b>BOHEMIAN NAT'L CEM.</b>	24D. LOCATION (City, town, or county) (State) <b>BALTIMORE MD.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 4 1972</b>		25B. NAME OF REGISTRAR <b>John Greblaukas</b>	
		25C. FUNERAL DIRECTOR <b>JOHN GREBLAUKAS</b>	
		ADDRESS <b>604 S. MILTON AVE</b>	





J-525

72 09443

STATE OF MARYLAND-DEATH  
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 09443

REG. NO.

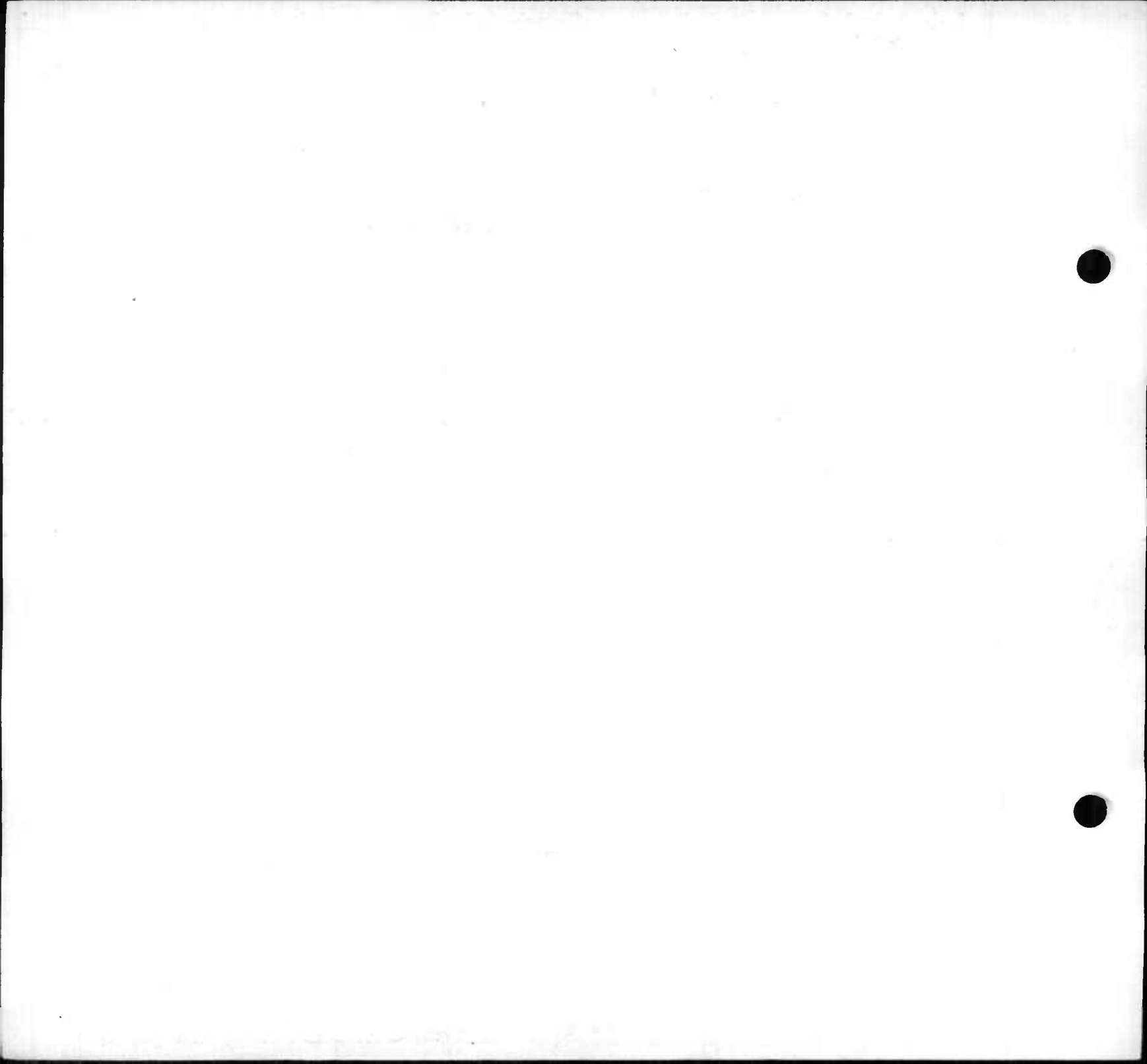
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>A</b> <b>Harry Johnson</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <b>10</b> Day <b>1</b> Year <b>72</b> Hour <b>M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>38 University Hospital</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month <b>10</b> Day <b>1</b> Year <b>72</b> Hour <b>9:40 a.</b> M.	
6. SEX <b>male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>4/9/1912</b>		10. AGE (In years last birthday) <b>60</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James A. Johnson</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dept Hgwy Balto City</b>	
15. MOTHER'S MAIDEN NAME <b>Emma L. Siemont</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW2 3/8/42 1/12/46</b>	
17. SOCIAL SECURITY NO. <b>215 10 9291</b>		18. INFORMANT <b>Miss Lillian Johnson</b>	
19. CAUSE OF DEATH <b>412.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1159 Washington Blvd</b>	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>no</b>		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>10/1/72</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	
24B. DATE <b>10/5/1972</b>		24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 4 1972</b>	
25B. NAME OF REGISTRAR <b>George J. Gonce</b>		25C. FUNERAL DIRECTOR <b>4001 Ritchie Hgwy</b>	

10/10/1913

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

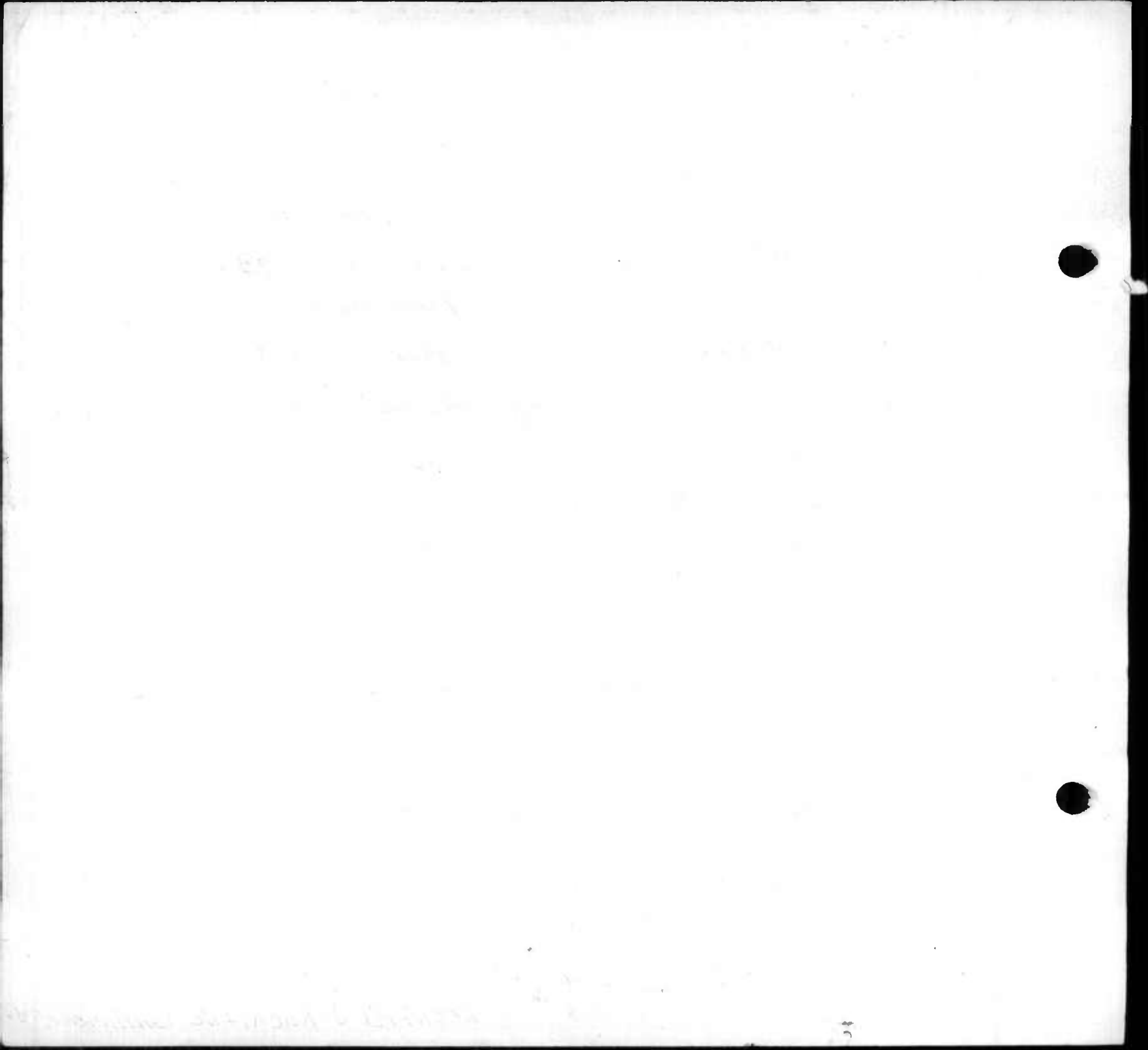
BALTIMORE CITY HEALTH DEPARTMENT				72 09444		REG. NO. 72 09444	
P-636				72 09444		STATE OF MARYLAND-DEMH	
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Charles H. PORTER</b>				9/29/72 1 5 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Sinai Hospital Belvedere Greenspring Ave. Baltimore, Maryland 21115</b>				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>3926 W GARRISON Blvd.</b>							
5. SEX <b>M</b>	6. RACE <b>Negra</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/17/20</b>	9. AGE (In years last birthday) <b>52</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cement mkr</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13. FATHER'S NAME <b>UNKNOWN</b>				14. MOTHER'S MAIDEN NAME <b>Lucille Porter</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>225-20-8787</b>		17. INFORMANT <b>Junious Porter Callahan</b>		ADDRESS <b>22435</b>
18. <b>202.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardio pulmonary arrest</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Lymphoma?</b> <b>Oesomatitis</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>9/29</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <b>(U)</b> (this hospital) attended the deceased from <b>9/29</b> 19 <b>72</b> to <b>9/29</b> 19 <b>72</b> that (I) <b>(We)</b> last saw the deceased alive on <b>9/29</b> 19 <b>72</b> and that in (my) <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>(We)</b> <b>(did not)</b> view the body after death.							
23A. SIGNATURE <b>Robert Kroovich</b>				23B. DATE SIGNED <b>9/27/72</b>		23C. PHYSICIAN'S NAME (Type) <b>Robert Kroovich</b>	
23D. ADDRESS <b>9008 Reisterstown Rd. Baltimore</b>							
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <b>10-5-1972</b>		24C. NAME of CEMETERY or CREMATORY <b>Zion Baptist Church</b>		24D. LOCATION (City, town, or county) (State) <b>Lottsburg Virginia 22511</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 4 1972</b>		25B. NAME OF REGISTRAR <b>Andrew W. Norton</b>		25C. FUNERAL DIRECTOR <b>Eugene W. Lee King George, Va</b>			



# FUNERAL DIRECTOR: IMPORTANT

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W-652		72 (9445)		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09445	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) WARNICK, Annabelle				2. DATE AND HOUR OF DEATH 10/2/72 9:00 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) NORTH CHARLES GEN HOSP. 49				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 2744			
5. SEX F		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-30-98	
9. AGE (In years last birthday) 73		10. UNDER 1 Yr. Months Days		11. UNDER 24 Hrs. Hours Min.		12. CITIZEN OF WHAT COUNTRY? USA	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME PETER HAGAN				14. MOTHER'S MAIDEN NAME MARGARET Mc CONAS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 219-01-0239A		17. INFORMANT JOSEPH R. WARNICK PA's CHAPT REISTERSTOWN MD.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE Uremia DUE TO, OR AS A CONSEQUENCE OF: (B) Hypertension DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Mos. Year Years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> Work At Work		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on OCT 2 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE George M. Kriesche, Jr.				23B. DATE SIGNED 10/2/72		23C. PHYSICIAN'S NAME (Type) GEORGE M. KRISCHKE, JR.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) I State	
BURIAL		10/6/72		New Cathedral Cem.		BALTIMORE, MD	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
OCT 4 1972		Andrew Whorton		LEONARD J. RUCK, INC		BALTIMORE, MD	

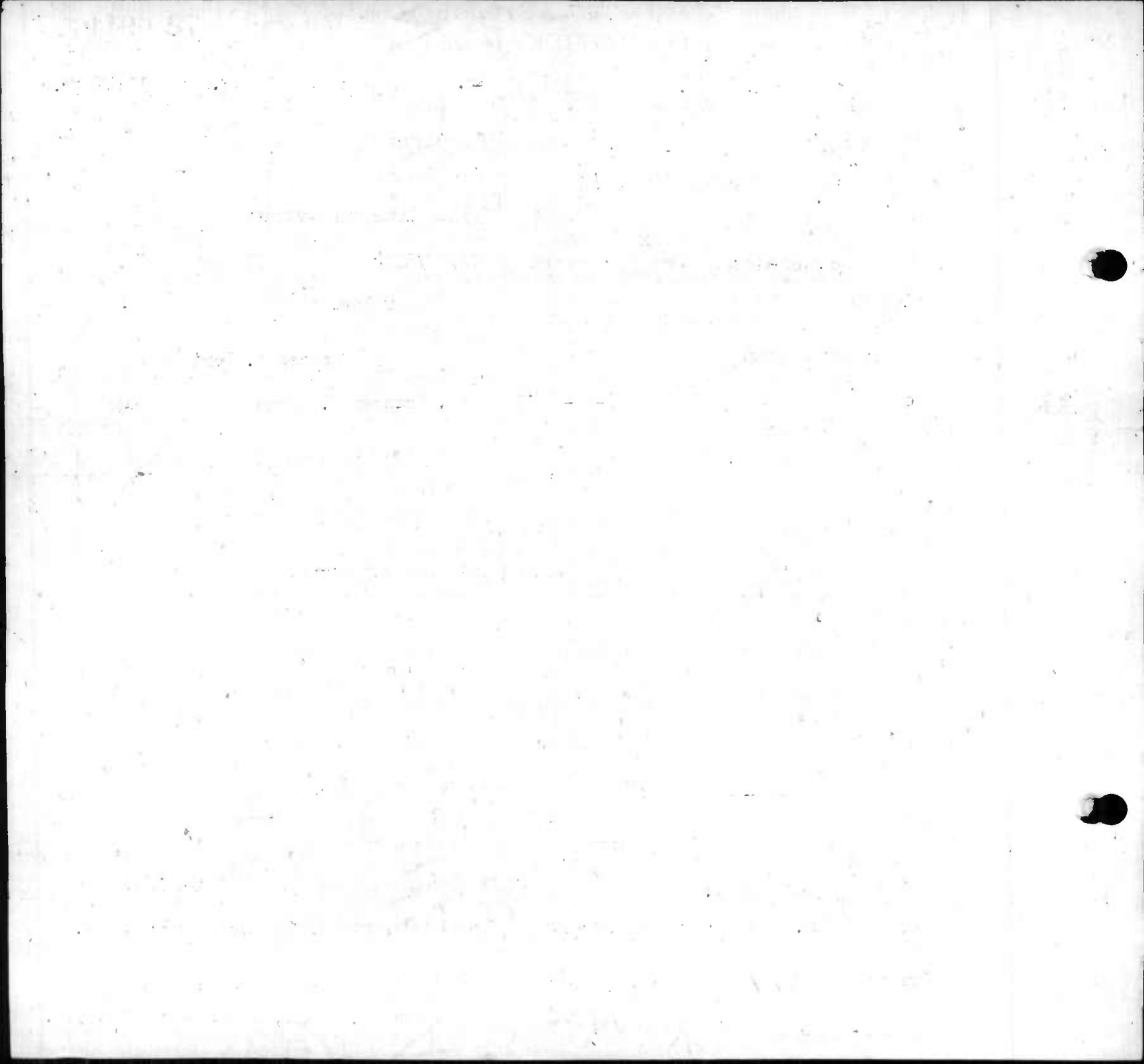


# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">72 09446</span>	
BIRTH NO. <span style="font-size: 1.2em;">B-650</span>				72 09446	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH	
ROLAND L. BROWN Sr.				October 1 1972 11:45 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				Maryland	
31/99 MERCY HOSPITAL (DOA)				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3312 Gibbons Avenue	
5. SEX male		6. RACE caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
				8. DATE OF BIRTH 12/30/1904	
				9. AGE (In years lost birthday) 67	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Leonard Brown				14. MOTHER'S MAIDEN NAME Frances P. Ford	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 577-05-6088A		17. INFORMANT Mrs. Frances K. Brown	
				ADDRESS Same	
18. <span style="font-size: 1.2em;">470.9</span> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  Myocardial Infarction  sudden	
				(B) DUE TO, OR AS A CONSEQUENCE OF:  ASCVD	
				(C) DUE TO, OR AS A CONSEQUENCE OF:  Cerebral Hemorrhage Old	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				1968	
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <del>(this hospital)</del> attended the deceased from <span style="font-size: 1.2em;">6/26/</span> 19 <span style="font-size: 1.2em;">72</span> to <span style="font-size: 1.2em;">Oct 1</span> 19 <span style="font-size: 1.2em;">72</span> , that (I) <del>(we)</del> last saw the deceased alive on <span style="font-size: 1.2em;">Aug 18</span> 19 <span style="font-size: 1.2em;">72</span> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> <del>(did not)</del> view the body after death.					
23A. SIGNATURE <i>John Russell Davis</i>				23B. DATE SIGNED 10/3/72	
23C. PHYSICIAN'S NAME (Type) Dr. John Russell Davis				23D. ADDRESS Medical Arts Building, Balto, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/5/72		24C. NAME of CEMETERY or CREMATORY Dulaney Valley Memorial Park	
				24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. OCT 4 - 1972		25B. NAME OF REGISTRAR <i>Sidney Whitson</i>		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. - Balto, Md.	

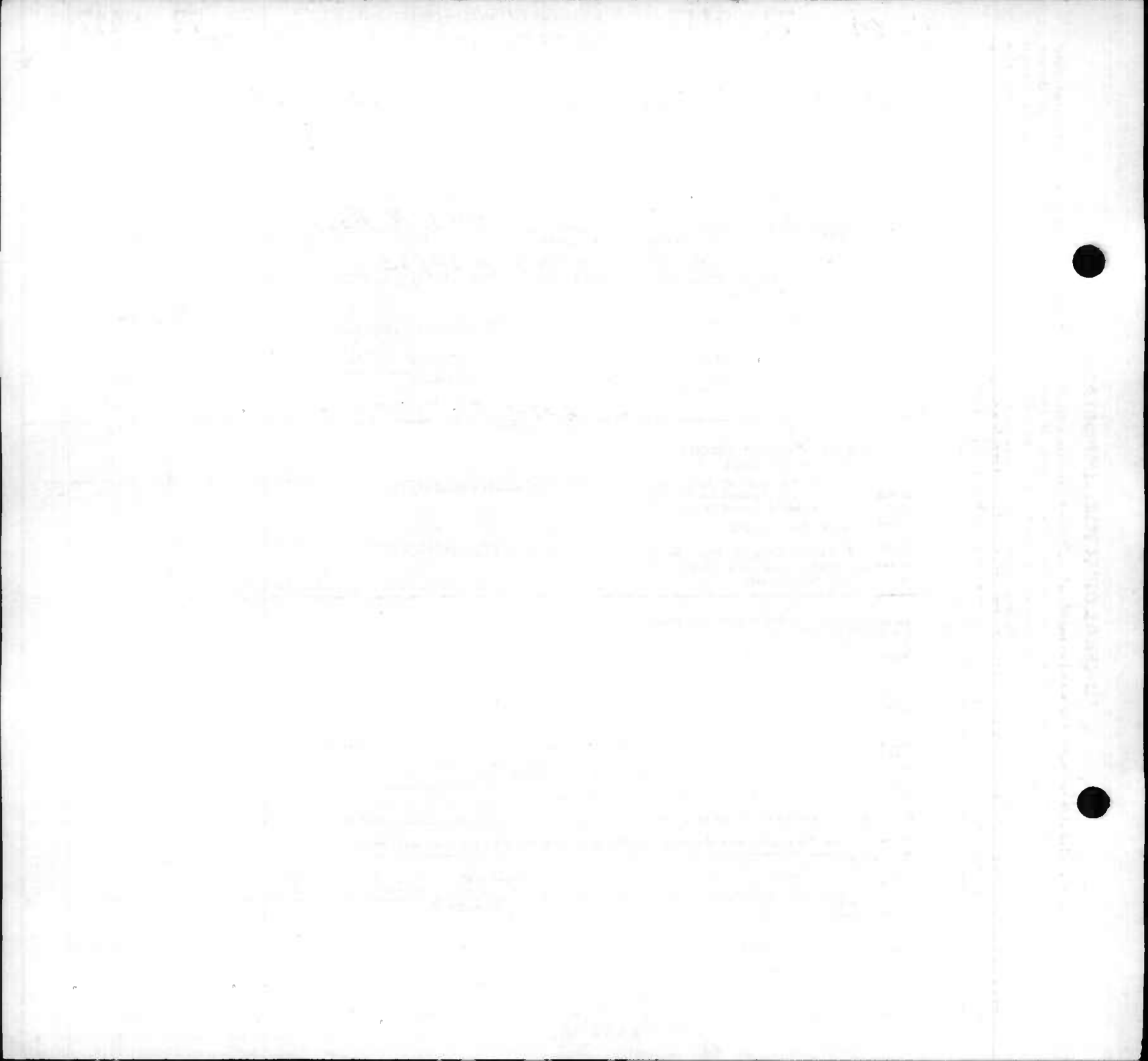




# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				72 09447	
CERTIFICATE OF DEATH				REG. NO. 72 09447	
BIRTH NO. <u>W-160</u>		1. NAME OF DECEASED (Type or Print) <u>Joseph Weber</u>			
2. DATE AND HOUR OF DEATH <u>October 3 1972</u> <u>4:25 A.</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Maryland General Hospital</u>			
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>602</u>		5. SEX <u>Male</u> 6. RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			
C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <u>423 N. Rose Street</u>		8. DATE OF BIRTH <u>10/24/23</u> 9. AGE (in years last birthday) <u>48</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seaman</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Joseph F. Weber</u>		14. MOTHER'S MAIDEN NAME <u>Frances Kolodziejski</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-16-5924</u>		17. INFORMANT ADDRESS <u>Mrs. Frances Weber 507 N. Glover Street</u>	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
(A) IMMEDIATE CAUSE <u>Pulmonary Edema</u> DUE TO, OR AS A CONSEQUENCE OF:					
(B) <u>Chronic Renal Failure</u> DUE TO, OR AS A CONSEQUENCE OF:					
(C) <u>Malignant Hypertension</u>					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>October 2</u> 19 <u>72</u> to <u>October 3</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>October 3</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>George E. Labocco MD</u> DEGREE				23B. DATE SIGNED <u>10/3/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>George E. Labocco MD</u> DEGREE				23D. ADDRESS <u>Maryland General Hospital Balto</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10/6/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary Cemetery</u>	
24D. LOCATION <u>Baltimore, Md.</u>		24E. German Hill Rd.		24F. (City, town, or county) (State) <u>MD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 4 1972</u>		25B. NAME OF REGISTRAR <u>Diary</u>		25C. FUNERAL DIRECTOR ADDRESS <u>George A. Weber 705 South Ann Street</u>	

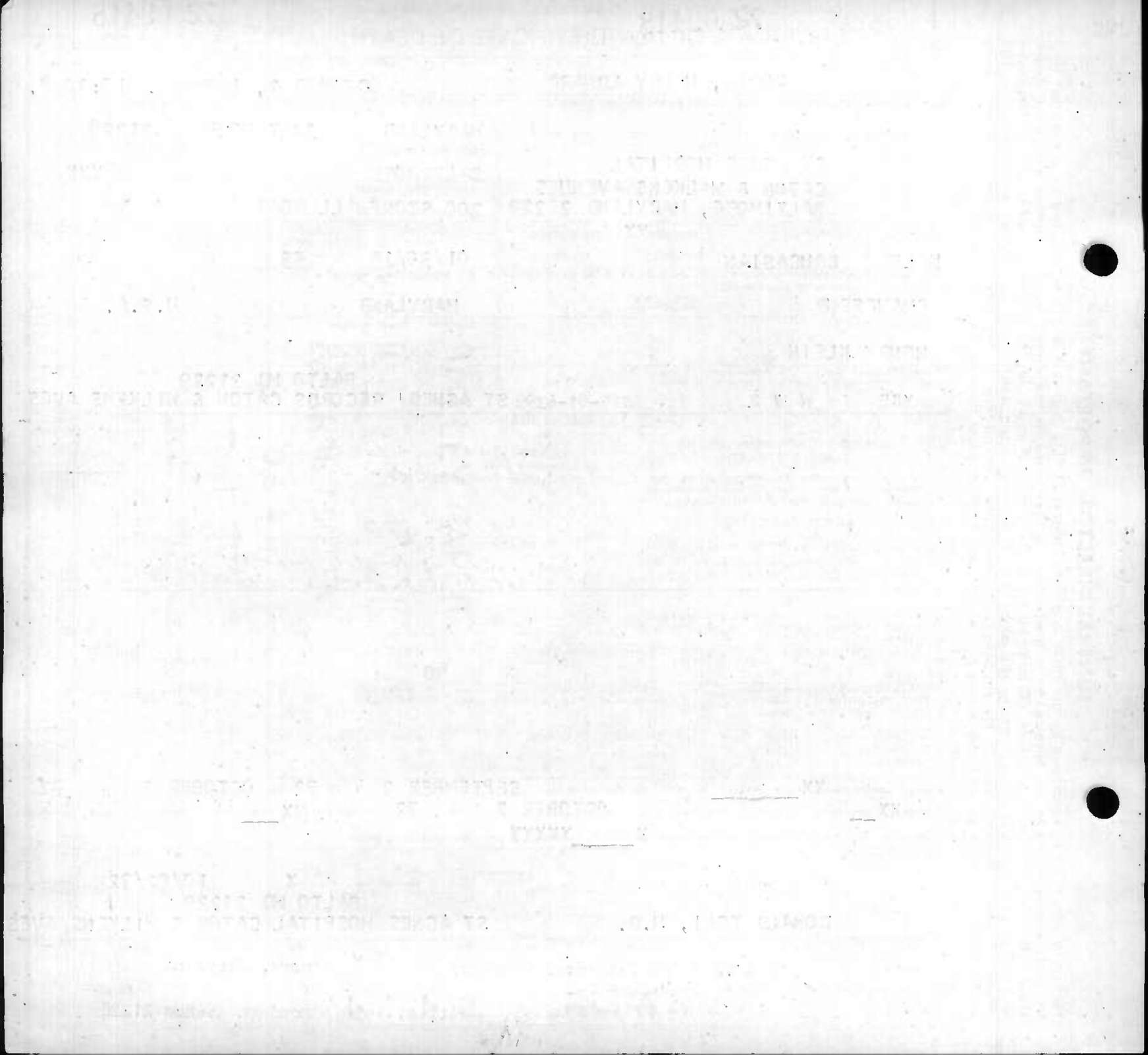


JMK

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-450		72 09448		BALTIMORE CITY HEALTH DEPARTMENT		72 09448	
BIRTH NO.		CERTIFICATE OF DEATH				REG. NO.	
1. NAME OF DECEASED (Type or Print)		KLEIN, HENRY EDWARD				2. DATE AND HOUR OF DEATH OCTOBER 2, 1972 10:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				5. STATE	
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229		MARYLAND BALTIMORE 21228				6. COUNTY	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN				D. INSIDE CITY LIMITS?	
		BALTIMORE				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER				200 STONEWALL ROAD	
S. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
MALE		CAUCASIAN		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		01/30/19 53	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
CHAUFFEUR		ESSKAY		MARYLAND		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
HENRY KLEIN				CATHERINE KIRBY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
YES W W 2				217-01-6399		BALTO MD 21229	
				ST AGNES' RECORDS CATON & WILKENS AVES			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		Respiratory failure					
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Cachexia					
		(C) Sarcoma of Right Kidney with metastases					
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <del>XX</del> (this hospital) attended the deceased from SEPTEMBER 2 19 72 to OCTOBER 2 19 72, that <del>XX</del> (we) lost saw the deceased alive on OCTOBER 2 19 72 and that in <del>XX</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>XX</del> (We) (did) <del>XXXXXX</del> view the body after death.							
23A. SIGNATURE						23B. DATE SIGNED	
Donald Tsai						10/02/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
DONALD TSAI, M.D.				BALTO MD 21229 ST AGNES HOSPITAL CATON & WILKENS AVES			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		10/6/72		New Cathedral Cemetery		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
OCT 4 1972		Sidney Whorton		Witzke, 11690		Edmondson Avenue 21228	



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BALTIMORE CITY HEALTH DEPARTMENT				72 09419		REG. NO.	
BIRTH NO.				72 09419		STATE OF MARYLAND - DUMM	
1. NAME OF DECEASED (Type or Print)				MATHILDA BROWN, KATHERINE MATHILDA		2. DATE AND HOUR OF DEATH SEPTEMBER 30, 1972 1:15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				MARYLAND BALTIMORE		21228	
ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 5903 CHARNWOOD ROAD				CHARNWOOD ROAD		5300	
5. SEX FEMALE		6. RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 03/04/00	
9. AGE (In years last birthday) 72		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE BROWN (LATE)				14. MOTHER'S MAIDEN NAME MARTHA LEINS (LATE)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 216-07-1635		17. INFORMANT BALTO MD 21229 ST AGNES' RECORDS CATON & WILKENS AVES	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Pulmonary Edema (B) DUE TO, OR AS A CONSEQUENCE OF: Acute Myocardial Infarction (C) ASCVD		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from SEPTEMBER 29 19 72 to SEPTEMBER 30 19 72, that (X) (we) last saw the deceased alive on SEPTEMBER 30 19 72 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.							
23A. SIGNATURE A. Escalante				23B. DATE SIGNED 09/30/72			
23C. PHYSICIAN'S NAME (Type) A. ESCALANTE, M.D.				23D. ADDRESS BALTO MD 21229 ST AGNES HOSPITAL CATON & WILKENS AVES			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/3/72		24C. NAME OF CEMETERY OR CREMATORY Loudon Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. OCT 4 1972		25B. NAME OF REGISTRAR Edmondson		25C. FUNERAL DIRECTOR Witzke		ADDRESS 1630 Edmondson Avenue 21228	

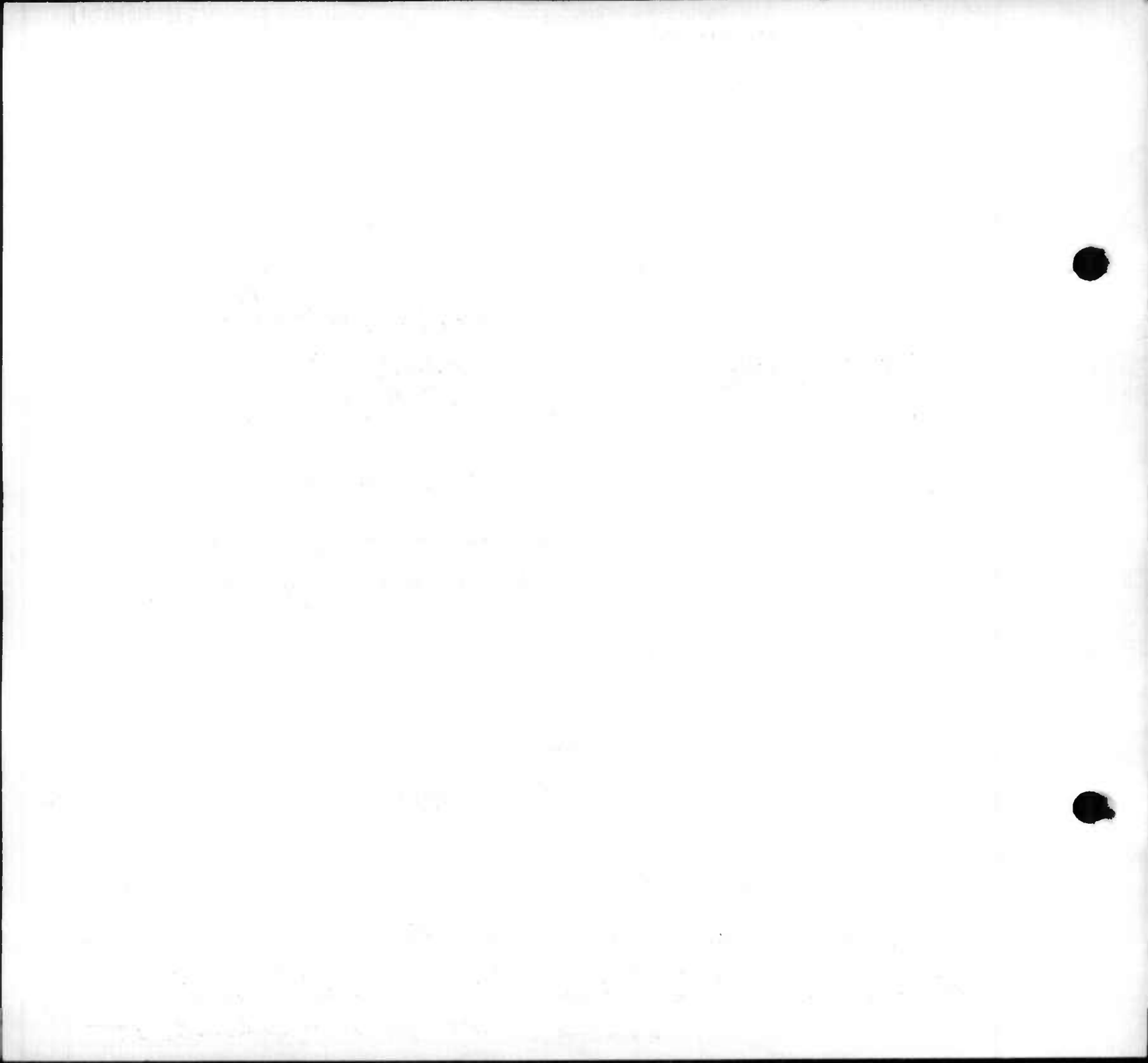




FUNERAL DIRECTOR: IMPORTANT

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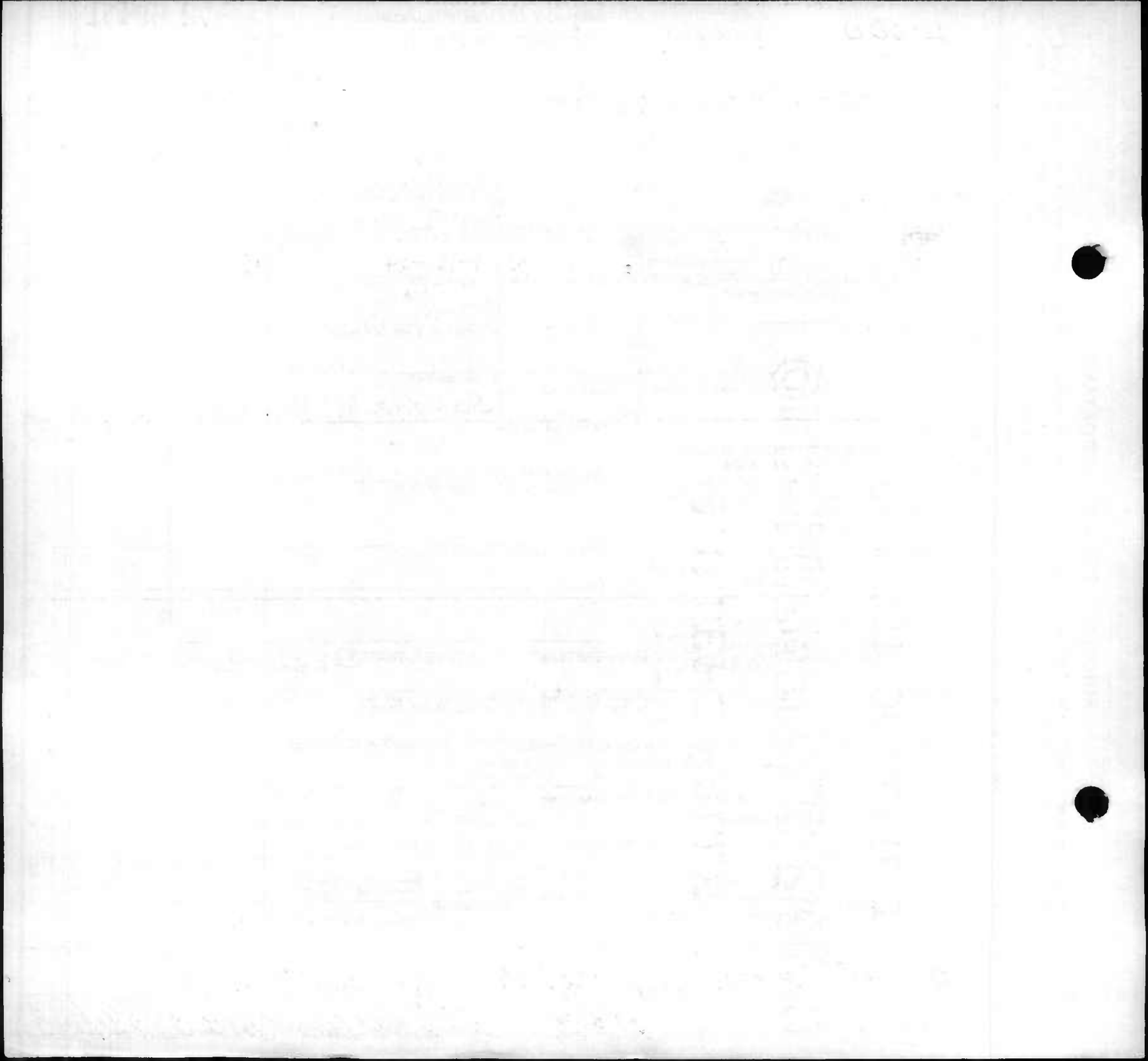
P-362 72 69450		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 69450 STATE OF MARYLAND-DEPT	
1. NAME OF DECEASED (Type or Print) <i>Emily Patterson</i>		2. DATE AND HOUR OF DEATH <i>9/30/72 6 30 A.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>Bolton Hill Nursing Home.</i> FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>1400 John Street Baltimore, Maryland.</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>1602</i>		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>Female</i> 6. RACE <i>Black</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>9-15-87</i> 9. AGE (In years last birthday) <i>85</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>UNKNOWN</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Northumberland Co. Va.</i>	
13. FATHER'S NAME <i>Octavius Wiggins</i>		14. MOTHER'S MAIDEN NAME <i>Emily ?</i>		12. CITIZEN OF WHAT COUNTRY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-30-6703</i>		17. INFORMANT <i>Mrs. Zeph Wiggins, 521 N. Gilmore St. Baltimore, Maryland</i>	
18. <i>412121</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Hypertensive Cerebral</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>years</i>	
(B) <i>arteriosclerosis generalized</i>		(C) <i>chronic brain syndrome</i>		<i>years</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>9/13</i> 19 <i>72</i> to <i>9/30</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>19</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>ae m...</i>		23B. DATE SIGNED <i>10/3/72</i>		23C. PHYSICIAN'S NAME (Type) <i>ALLAN H. MACHT MD</i>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>10/5/72</i>		24C. NAME OF CEMETERY or CREMATORY <i>W. T. Culson Cem</i>	
24D. LOCATION (City, town or county) (State) <i>Balto. Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>OCT 4 1972</i>		25B. NAME OF REGISTRAR <i>Lidney...</i>	
25C. FUNERAL DIRECTOR <i>Wm. H. Schuler</i>		25D. ADDRESS <i>314 N. Schuler St</i>			



# FUNERAL DIRECTOR: IMPORTANT

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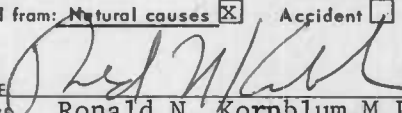
L-000 72 09451		BALTIMORE CITY HEALTH DEPARTMENT		72 09451	
BIRTH NO.		REG. NO.		STATE OF MARYLAND-DEATH	
1. NAME OF DECEASED (Type or Print) <b>Lee, Mrs. Annie Mae</b>		2. DATE AND HOUR OF DEATH <b>Oct. 1, 1972 11:55 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Bon Secours Hospital</b>		A. STATE <b>Maryland</b>		B. COUNTY <b>2002</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>2877 Kinsey Ave.</b>			
5. SEX <b>Female</b>	6. RACE <b>Black</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>1-12-24</b>	9. AGE (In years last birthday) <b>48</b>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
13. FATHER'S NAME <b>Thomas, Elijah</b>		14. MOTHER'S MAIDEN NAME <b>Mae Cromatie</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>258-28-4110</b>		17. INFORMANT <b>Sandra Williams 2877 Kinsey Ave</b>	
				ADDRESS	
18. <b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>~ 1 YR.</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE METASTASIS OF POSSIBLE CA. CERVIX TO THE BRAIN DUE TO, OR AS A CONSEQUENCE OF:			
		(B) _____ DUE TO, OR AS A CONSEQUENCE OF:			
		(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/17/72</b> to <b>10/1/72</b> that (I) (we) last saw the deceased alive on <b>10/1/72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Chaban</b>		M.D. DEGREE <b>M.D.</b>		23B. DATE SIGNED <b>10/1/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>CHAIHAN UNGSHAKORN</b>		23D. ADDRESS <b>BON SECOURS HOSP. 2025 W. FAYETTE ST. BALTIMORE, MD-21223</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/5/72</b>		24C. NAME of CEMETERY or CREMATORY <b>St. Chaban Cem. Balto Md</b>	
24D. LOCATION <b>Baltimore</b>		24E. CITY, TOWN, or county <b>Baltimore</b>		24F. STATE <b>Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 4 1972</b>		25B. NAME OF REGISTRAR <b>Sandra Williams</b>		25C. FUNERAL DIRECTOR <b>Williams Funeral Home 3199 Schenck St</b>	
				ADDRESS	



BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JOSEPH T. WALTERS</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <span style="float:right">M.</span>			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 431 N. Lakewood Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>October 2, 1972 1:30 P.</b> <span style="float:right">M.</span>			
6. SEX <b>Male</b>		7. RACE <b>White</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>8-17-1907</b>		10. AGE (In years last birthday) <b>65</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>CHARLES A. WALTERS, SR.</b>			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PIPE FITTER</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>CROWN, CORK &amp; SEAL</b>		15. MOTHER'S MAIDEN NAME <b>ANNIE F. TALBOT</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>212-10-1954</b>		18. INFORMANT ADDRESS <b>Mrs. Hilda S. WALTERS.</b>	
19. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p><b>412.4</b></p> <p><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b></p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p><b>ANTECEDENT CAUSES</b></p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</p> </div> <div style="width: 50%;"> <p><b>Arteriosclerotic cardiovascular disease</b></p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) _____ DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) _____</p> </div> </div>					
20. DATE OF OPERATION <b>10/5/72</b>					
20B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NO</b>					
21. AUTOPSY? (Yes or No) <b>no</b>					
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED <b>10/3/72</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10/5/72</b>		24C. NAME of CEMETERY or CREMATORY <b>HOLY REDEEMER CEM.</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTO., MD.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 4 1972</b>			
25B. NAME OF REGISTRAR <b>Arthur J. [illegible]</b>		25C. FUNERAL DIRECTOR ADDRESS <b>2334 Jefferson St</b>			

X

X

8-17-1967

CS

CHARLES A. HARRIS, JR.  
U.S.A.  
JAMES T. HARRIS  
JAMES T. HARRIS  
JAMES T. HARRIS

no

James T. Harris

James T. Harris  
James T. Harris

STATE OF MARYLAND - DEPT. OF HEALTH									
Baltimore City Health Department									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
REG. NO. 72 09453									
BIRTH NO. C-455									
1. NAME OF DECEASED (Type or Print) HENRY J. COLEMAN					2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.				
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If not in hospital or institution, give street address or location) 1700 N. Broadway					3. DATE PRONOUNCED DEAD Month Day Year Hour 10 1 1972 10:40a M.				
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 806									
6. SEX male		7. RACE negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 2-25-42		10. AGE (In years last birthday) 30		11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN COLEMAN	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		14B. KIND OF BUSINESS OR INDUSTRY Construction		15. MOTHER'S MAIDEN NAME Ida Richmond					
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 217-38-1625		18. INFORMANT ADDRESS Miss Mattie Coleman 1700 N. Broadway					
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Gunshot wound of chest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) yes									
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1700 N. Broadway 806									
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 10-1-72 a.m. 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> 22F. HOW DID INJURY OCCUR? Shot by unknown assailant.									
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 10-2-72									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 10-5-72 24C. NAME OF CEMETERY or CREMATORY Md. National Memorial Park Laurel, Maryland 24D. LOCATION (City, town, or county) (State)									
25A. DATE REC'D BY HEALTH DEPT. OCT 4 1972 25B. NAME OF REGISTRAR Sidney H. Brown 25C. FUNERAL DIRECTOR ADDRESS Randolph J. Collick 2431 E. Oliver St.									



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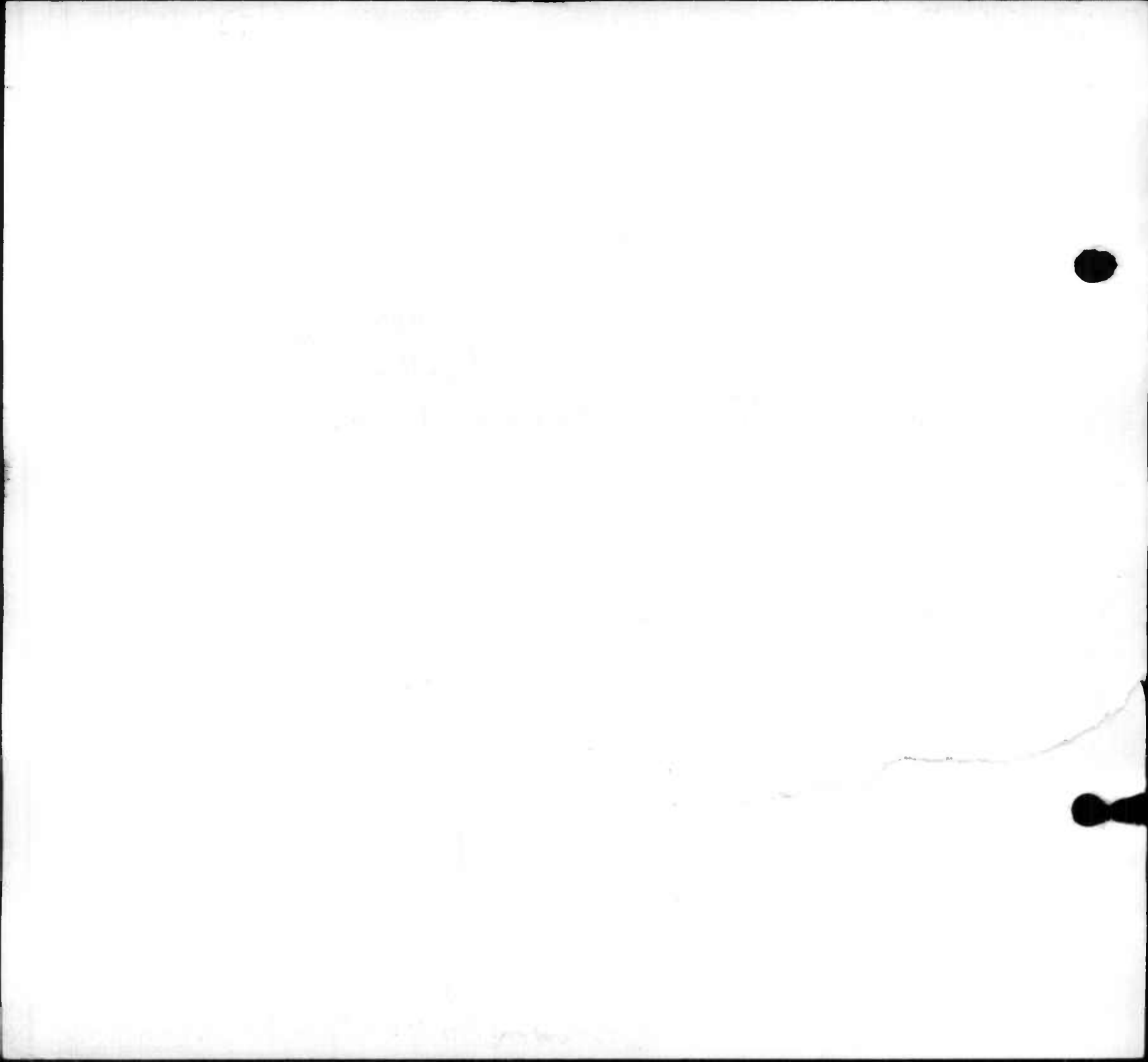
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Lancaster, E. A. 30

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 09454 BALTIMORE CITY HEALTH DEPARTMENT		72 09454	
CERTIFICATE OF DEATH			
BIRTH NO.		REG. NO. MD. DEPT. OF HEALTH & MENTAL HYGIENE	
1. NAME OF DECEASED (Type or Print) <u>Lillian Ford</u>		2. DATE AND HOUR OF DEATH <u>9/30/72</u> <u>11:40 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>2 Maryland</u> B. COUNTY <u>2004</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Univ. of Maryland Hospital</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>2105 Hollins Street</u>			
5. SEX <u>F</u>	6. RACE <u>B</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/26/97</u>
9. AGE (In years last birthday) <u>75</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dietician</u>	
11. BIRTHPLACE (State or foreign country) <u>Swainsburg GA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Ford</u>		14. MOTHER'S MAIDEN NAME <u>Martha Ford</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>N/A</u>		16. SOCIAL SECURITY NO. <u>218-09-6042</u>	
17. INFORMANT <u>Pearl Fraction</u>		ADDRESS <u>2105 Hollins St</u>	
18. CAUSE OF DEATH <u>238.1</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>(R) Intracranial Neoplasm</u> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>9/30/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>No</u>	
20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8/6</u> 19 <u>72</u> to <u>9/30</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>9/30</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Richard A. Tomasulo M.D.</u>		23B. DATE SIGNED <u>9/30/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Richard Tomasulo M.D.</u>		23D. ADDRESS <u>Univ. of Md. Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-4-72</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 4 1972</u>		25B. NAME OF REGISTRAR <u>Sidney H. Heston</u>	
25C. FUNERAL DIRECTOR <u>Morton Dyett F.H. 1701 - Lauvews St.</u>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 69455	
72 69455				STATE OF MARYLAND-DEMD	
BIRTH NO.				DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		MARY LORRAINE LEWIS		2. DATE AND HOUR OF DEATH Oct. 3, 1972 4: 15 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. CITY OR TOWN	
FULL NAME OF HOSPITAL OR INSTITUTION <b>US Public Health Service Hospital 3100 Wyman Parkway</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Md.</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>F</b>		6. RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>9/9/34</b>		9. AGE (In years last birthday) <b>38</b>		10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>REGISTERED NURSE</b>		11. BIRTHPLACE (State or foreign country) <b>Md. BALTIMORE</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>James Wilson</b>		14. MOTHER'S MAIDEN NAME <b>Marguerite Jones</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-32-6878</b>		17. INFORMANT <b>Records- US PHS Hospital, Balto, Md.</b>	
18. CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Metastatic carcinoma</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>June 5</b> 19 <b>72</b> to <b>Oct. 3</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>Oct. 3</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Howard S. Weldon, SA Surg (R)</b>				23B. DATE SIGNED <b>10/3/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Weldon Md.</b>				23D. ADDRESS <b>US PHS Hospital, Balto, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>10-7-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>NEW CATHEDRAL CEMETERY</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT. <b>OCT 4 1972</b>			
25B. NAME OF REGISTRAR <b>Sidney H. Weston</b>		25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F. H. 1701 LAURENS ST.</b>			

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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09456	
72 09456				STATE OF MARYLAND-DHMH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Gorham Louise</b>		2. DATE AND HOUR OF DEATH <b>10/2/72 9<sup>23</sup> P M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>Johns Hopkins Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2562</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Johns Hopkins Hospital</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <b>867 Bethune Road</b>	
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/10/23</b>	9. AGE (In years last birthday) <b>49</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Tarbovo, W.-C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Jessie Gorham</b>		14. MOTHER'S MAIDEN NAME <b>Minnie Harper</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>N/A</b>		16. SOCIAL SECURITY NO. <b>219-18-8378</b>		17. INFORMANT <b>Florence Harris - 3011-Windsor Ave</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>250.5</b>		CAUSE OF DEATH <b>Myocardial Infarction - 3hrs.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Embolization</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>DIABETES MELLITUS, HYPERTENSION - 4 YEARS</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Cerebral Vascular Accident 2 weeks</b>		19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/11 1972</b> to <b>10/2 1972</b> , that (I) (we) last saw the deceased alive on <b>10/2 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>John W. Kraus M.D.</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>10/2/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>John W. Kraus M.D.</b>		23D. ADDRESS <b>550 N. Broadway</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-6-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cem</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto, Md.</b>		24E. NAME OF REGISTRAR <b>Sidney W. Dyer</b>		24F. FUNERAL DIRECTOR <b>Dyett F.H.</b>	
24G. DATE REC'D BY HEALTH DEPT. <b>OCT 4 1972</b>		24H. ADDRESS <b>1701-Kravens St.</b>			

10/1/32

John W. Brown

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J-635		72 09457		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09457	
BIRTH NO.		CERTIFICATE OF DEATH				STATE OF MARYLAND	
1. NAME OF DECEASED (Type or Print) <u>Thelma E. Jordan</u>				2. DATE AND HOUR OF DEATH <u>10-1-72</u> <u>6</u> P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Maryland General Hospital</u> <u>48</u>				A. STATE <u>Md.</u> B. COUNTY <u>805</u>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>Balt</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>E. North Ave. 1806</u>			
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-21-27</u>	9. AGE (in years last birthday) <u>45</u>	10. Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Bishop Creighton</u>				14. MOTHER'S MAIDEN NAME <u>Thelma</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO. <u>217-22-2528</u>		17. INFORMANT ADDRESS <u>SKIRO JORDAN 1806 E. NORTH AVE</u>			
18. <u>3-9-0-0-1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>MI</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>15 Min</u>	
(B) <u>Hypertensive ASCVD; LVH; Anemia</u> DUE TO, OR AS A CONSEQUENCE OF:				(C) <u>Chronic Pyelonephritis - Renal Failure; GI bleeding</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>9-11</u> 19 <u>72</u> to <u>10-1</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>10-1</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Arnold G. Alexander MD</u>				23B. DATE SIGNED <u>10-1-72</u>		23C. PHYSICIAN'S NAME (Type) <u>Arnold G. Alexander MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-6-72</u>		24C. NAME of CEMETERY or CREMATORY <u>Balto. Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Balt. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 4 1972</u>				25B. NAME OF REGISTRAR <u>Shirley H. Hinton</u>		25C. FUNERAL DIRECTOR ADDRESS <u>WM. C. MARCH 928 E. North Ave</u>	

VA  
Thelma

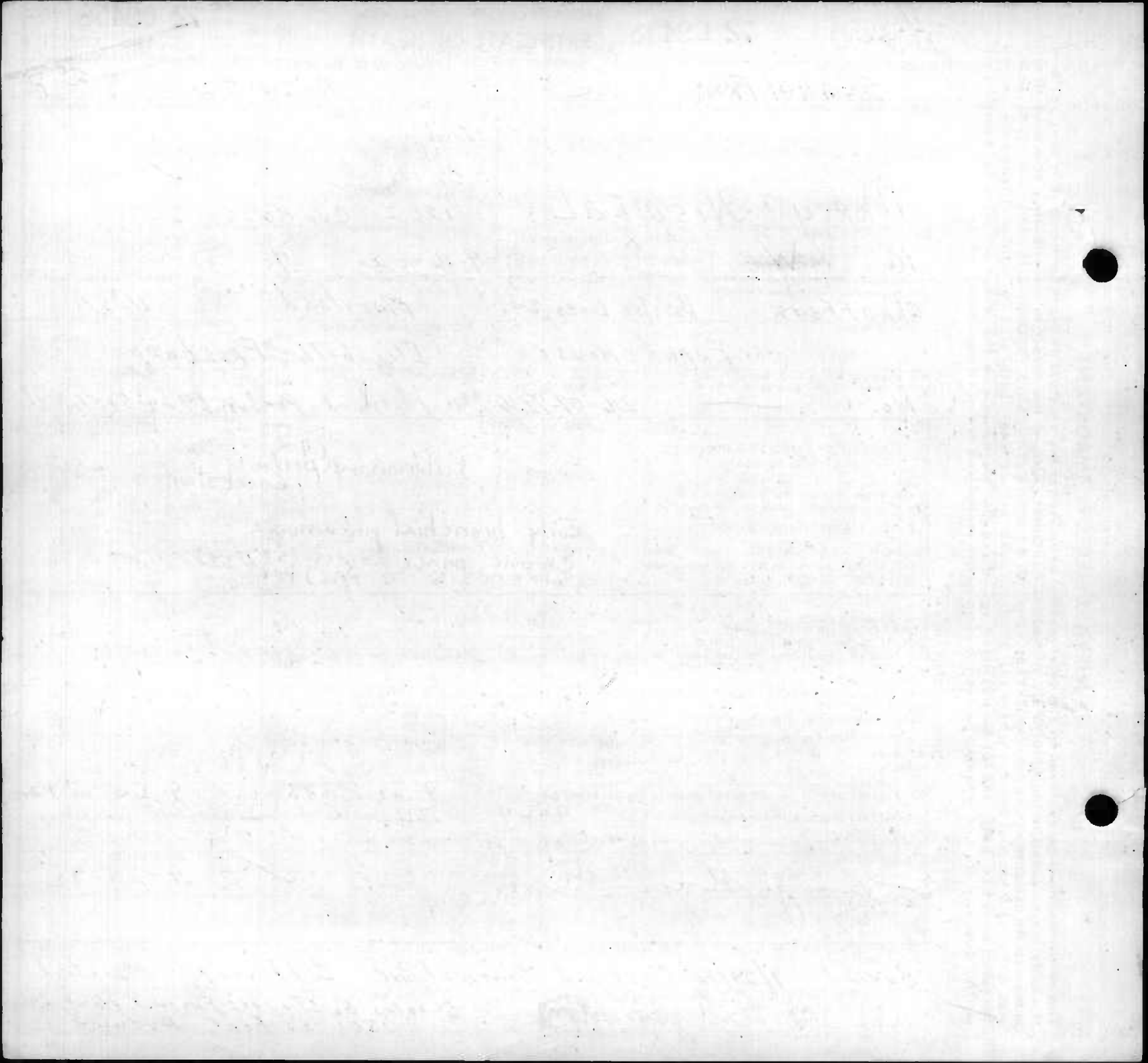
Cheryl

517-232-5200 Skina Jordan 1200 E. 1st St. - 112

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09458		72 09458	
H-200				72 09458		72 09458	
BIRTH NO.				72 09458		72 09458	
BIRTH NO.				72 09458		72 09458	
1. NAME OF DECEASED (Type or Print) <b>Samuel Frank House</b>				2. DATE AND HOUR OF DEATH <b>9-24-72 8:50 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>Mercy Hospital</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>2401</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Mercy Hospital</b>				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>1202 COOKSIE ST</b>							
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-16-02</b>	9. AGE (In years lost birthday) <b>70</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHAUFFEUR</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Bristow Lines, Inc.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>FRANK House</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Frosburg</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-07-7836</b>		17. INFORMANT ADDRESS <b>Mrs. Mildred Phibus 5924 Sefton Rd</b>			
18. CAUSE OF DEATH <b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary Coema e Congestion</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(A) Early bronchial pneumonia</b> <b>(B) Chronic pancreatitis (severe)</b> <b>(C) Cirrhosis &amp; Ascites</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>9-21 1972</b> to <b>9-24 1972</b> that (I) (we) last saw the deceased alive on <b>9-24 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Ernest J. Brown MD</b>				23B. DATE SIGNED <b>9-24-72</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <b>Ernest J. Brown</b>				23D. ADDRESS <b>1501 E. Fort Avenue</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/29/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Morland Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 4 1972</b>		25B. NAME OF REGISTRAR <b>Adrian H. Brown</b>		25C. FUNERAL DIRECTOR <b>Stevens Funeral Home, Inc.</b>			
				ADDRESS <b>1501 E. Fort Avenue</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-140		72 09459		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09459	
BIRTH NO.				STATE OF MARYLAND-DMH			
1. NAME OF DECEASED (Type or Print) <b>ANNA M. FEIBEL</b>				2. DATE AND HOUR OF DEATH <b>9-24-72</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2401</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>South Baltimore General Hosp.</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>F</b>		6. RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-17-13</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waitress</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Read's Drug</b>		9. AGE (In years last birthday) <b>59</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>William Loose</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>219-18-0610</b>		17. INFORMANT <b>Michael Feibel</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Acute Coronary Occlusion</b>				19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerotic Cardiac Vascular Disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Instantaneous</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>January 1968</b> to <b>Sept. 24 1972</b> , that (I) (we) lost saw the deceased alive on <b>9-24 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Rolando V. Gocoyod</b>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>9-26-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Rolando V. Gocoyod</b>				23D. ADDRESS <b>707 E. Fort Ave. Balt. Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>9/28/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery Baltimore, Md.</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 4 1972</b>		25B. NAME OF REGISTRAR <b>Audrey Whitson</b>		25C. FUNERAL DIRECTOR <b>CHARLES L. STEVENS FUNERAL HOME, INC.</b>			
				ADDRESS <b>1501 EAST FORT AVENUE</b>			





STATE OF MARYLAND - BALTIMORE CITY HEALTH DEPARTMENT				72 09460			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				72 09460			
BIRTH NO. 72-13635				REG. NO.			
1. NAME OF DECEASED (Type or Print) CHRISTINA D. COSNER				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) So. Balto. Gen. Hosp. (DOA) 4/31/72				3. DATE PRONOUNCED DEAD Month Day Year Hour 9 26 1972 12:44p M.			
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2403				C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
6. SEX female		7. RACE white		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 1304 Williams St.	
9. DATE OF BIRTH 9/5/72		10. AGE (In years last birthday) 3 wks.		If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.		13. FATHER'S NAME James Cosner	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		15. MOTHER'S MAIDEN NAME Dale Long			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			
17. SOCIAL SECURITY NO.		18. INFORMANT James Cosner 1304 Williams St.		ADDRESS			
19. 466X I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Sudden Death in Infancy Acute bronchitis and bronchopneumonia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Russell S. Fisher, M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) DATE SIGNED 9-26-72 ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
24A. BURIAL CREMATION, REMOVAL (Specify) Barzel		24B. DATE 9/30/72		24C. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT OCT 4 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Charles E. Stevens Funeral Home, Inc.		ADDRESS 504 E. Fort Ave.	



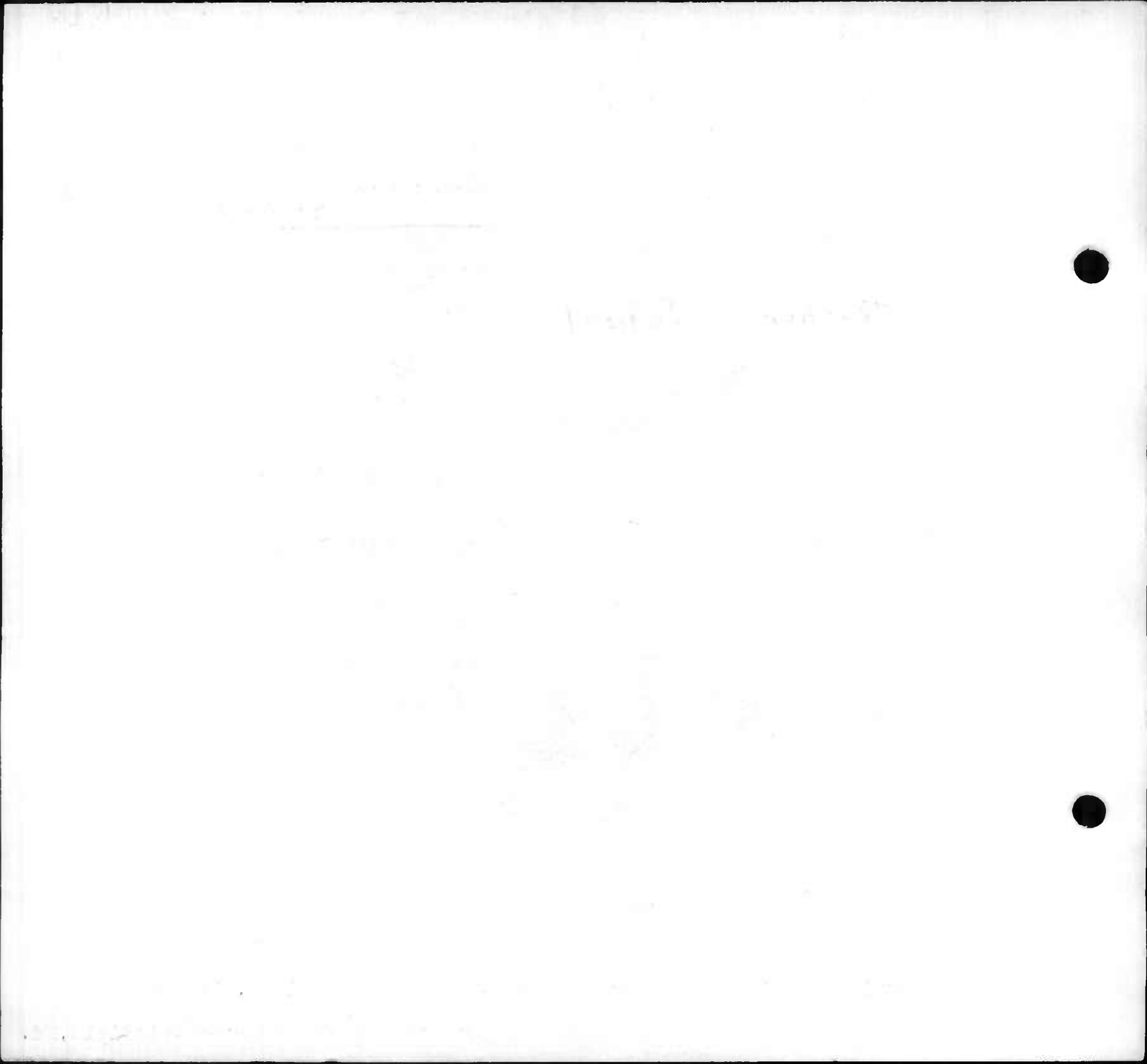
10/31/72 - Letter from Dr. Russel S. Fisher, Chief Medical Examiner, 10/30/72.

*ABP*

*Dr. Russel S. Fisher*

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-500		72 09461		BALTIMORE CITY HEALTH DEPARTMENT		72 09461	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <u>Boone, Athol</u>				2. DATE AND HOUR OF DEATH <u>Sept 26, 1972 @ 7<sup>15</sup> P. M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>University of Maryland Hospital</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Silver Spring</u> C. CITY OR TOWN <u>Crisfield</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>Route 1 4717 New Hampshire Avenue</u>			
5. SEX <u>female</u>	6. RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-25-95</u>	9. AGE (In years last birthday) <u>77</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>School</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>William Byrd</u>				14. MOTHER'S MAIDEN NAME <u>Sallie Sterling</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>717-07-9197</u>		17. INFORMANT <u>Lorese Katen (Daughter)</u>		ADDRESS <u>14717 New Hampshire Ave</u>	
18. CAUSE OF DEATH							
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <u>RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>CARCINOMATOSIS</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>9-26-72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Sept. 9, 2:15pm 1972</u> to <u>Sept 26, 7:15pm 1972</u> that (I) (we) last saw the deceased alive on <u>Sept 26, 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>C. W. Neal, M.D.</u>				23B. DATE SIGNED <u>9-26-72</u>		23C. PHYSICIAN'S NAME (Type) <u>C. W. Neal, M.D.</u>	
23D. ADDRESS <u>University Hosp. Balto. Md</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/30/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Crisfield, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 4 1972</u>		25B. NAME OF REGISTRAR <u>James L. Harmon</u>		25C. FUNERAL DIRECTOR <u>James L. Harmon</u>		ADDRESS <u>Crisfield, Md.</u>	



72 09462		STATE OF MARYLAND - DEHE		BALTIMORE CITY HEALTH DEPARTMENT		72 09462	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO.			
BIRTH NO.							
1. NAME OF DECEASED (Type or Print) Elizabeth <del>Jenkins</del> D. Jenkins				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year Hour 9 29 72 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 Union Memorial Hospital				3. DATE PRONOUNCED DEAD Month Day Year Hour 9 29 72 2:05 p. M.			
6. SEX female				7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Feb 14 1880				10. AGE (In years last birthday) 92		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Robert Dall		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerical Worker	
15. MOTHER'S MAIDEN NAME Helen				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 214 24 6096	
18. INFORMANT George W. Schmidt				ADDRESS same			
19. 4124 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Min.)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE: <i>Peter Lipkovic</i> M.D. EXAMINER'S NAME (Type): Peter Lipkovic, M.D.  CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>  DATE SIGNED: 9/30/72							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2 Oct 72		24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. OCT 4 1972		25B. NAME OF REGISTRAR <i>Anthony...</i>		25C. FUNERAL DIRECTOR Bryce Funeral Home, Baltimore, Maryland		ADDRESS Bryce Funeral Home, Baltimore, Maryland	

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H-620

72.09463

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

72 09463

## CERTIFICATE OF DEATH

STATE OF MARYLAND-DMH

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Lee Harris

2. DATE AND HOUR OF DEATH

10/1/72

15.55 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)31 Baltimore City Hospitals 21224  
4940 Eastern Ave., Baltimore, Md.

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

Maryland

Baltimore

C. CITY OR TOWN

Edgewater

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

2505 Oak Manor Road 21219

5. SEX

Male

6. RACE

Caucasian

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

May 22-1941

9. AGE (In years  
last birthday)

31

If Under 1 Yr.

Months: Days

If Under 24 Hrs.

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Crane operator

10B. KIND OF BUSINESS OR INDUSTRY

Edgewater Co

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Marvin

Harris

14. MOTHER'S MAIDEN NAME

Edna Aivriekson

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

1961-1964

16. SOCIAL  
SECURITY NO.

219-38-1904

17. INFORMANT

Records: BCH-4940 Eastern Ave. 21224

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

18. Cause of Death

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Crem Negative Sepsis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(B) DUE TO, OR AS A CONSEQUENCE OF:

Massive stress ulcer bleeding  
Ruptured liver + spleen

1 month

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

8/28/72

19B. CONDITION FOR WHICH OPERATION

WAS PERFORMED

Ruptured liver + spleen

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Bethlehem Steel

21C. WHERE DID  
INJURY OCCUR?

Bethlehem Steel Baltimore

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

8 28 72

21E. INJURY OCCURRED

While At Work ☒Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

Riding tractor at work

22. I certify that (I) (this hospital) attended the deceased from 8/28 1972 to 10/1 1972  
that (I) (we) last saw the deceased alive on 10/1 1972 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Noble Hansen MD

DEGREE

Attending ☒ Phys.Med.  
Director ☐Staff  
Phys. ☐

23B. DATE SIGNED

10/1/72

23C. PHYSICIAN'S  
NAME (Type)

Noble Hansen, MD

23D. ADDRESS

Baltimore City Hospitals, 4940 Eastern  
Ave. Baltimore, Md. 2122424A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

Oct. 4, 1972

24C. NAME OF CEMETERY OR CREMATORY

Galvary Missionary Baptist Church, Cemetery

24D. LOCATION

Rising Sun,

(City, town, or county)

Baltimore

(State)

Maryland

25A. DATE REC'D BY HEALTH DEPT.

OCT 4 1972

25B. NAME OF REGISTRAR

Anthony [illegible]

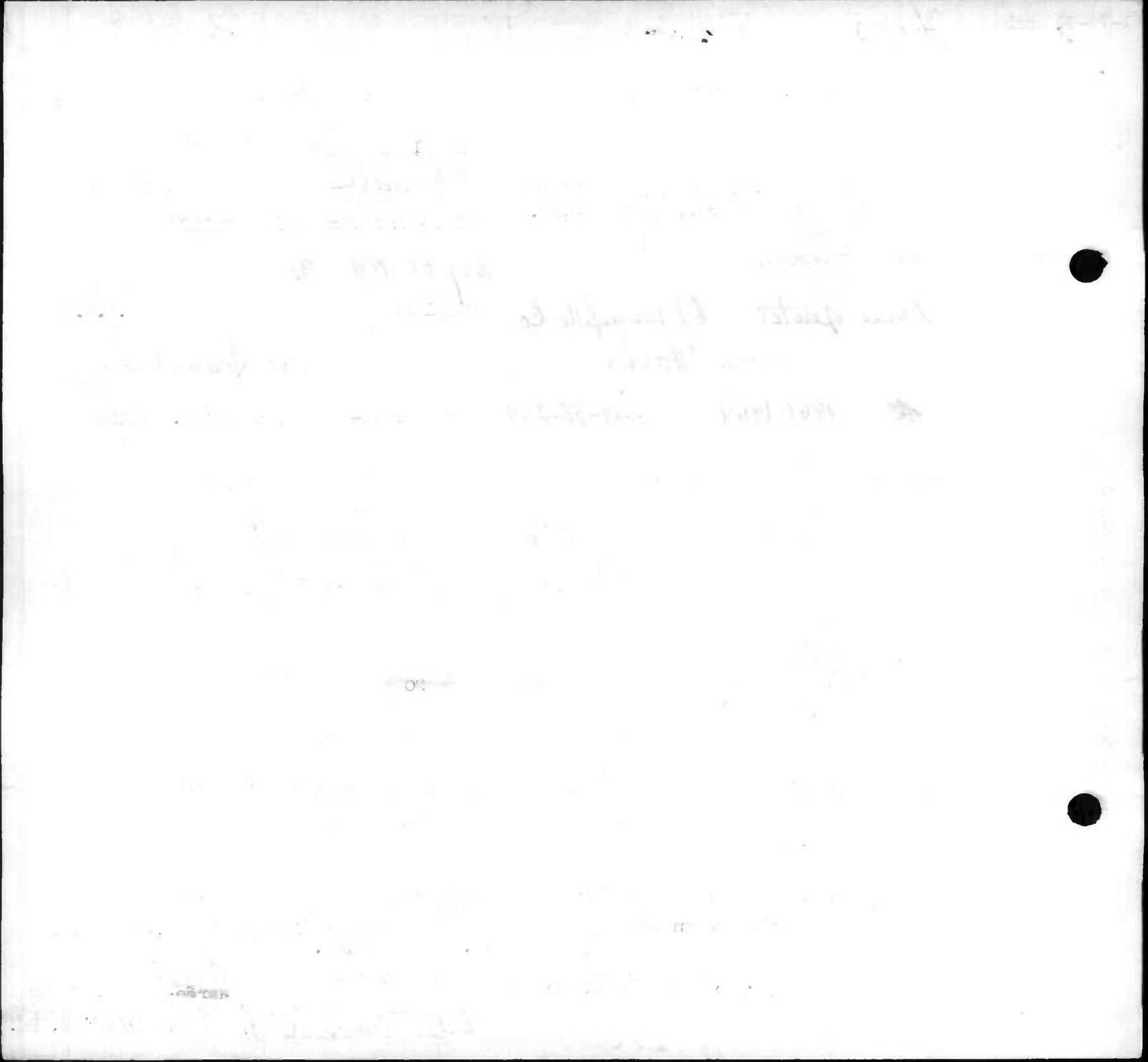
25C. FUNERAL DIRECTOR

Tarring Funeral Home.

ADDRESS

333 S. Parke St.  
Aberdeen, Md.RELEASED BY MEDICAL EXAMINER  
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

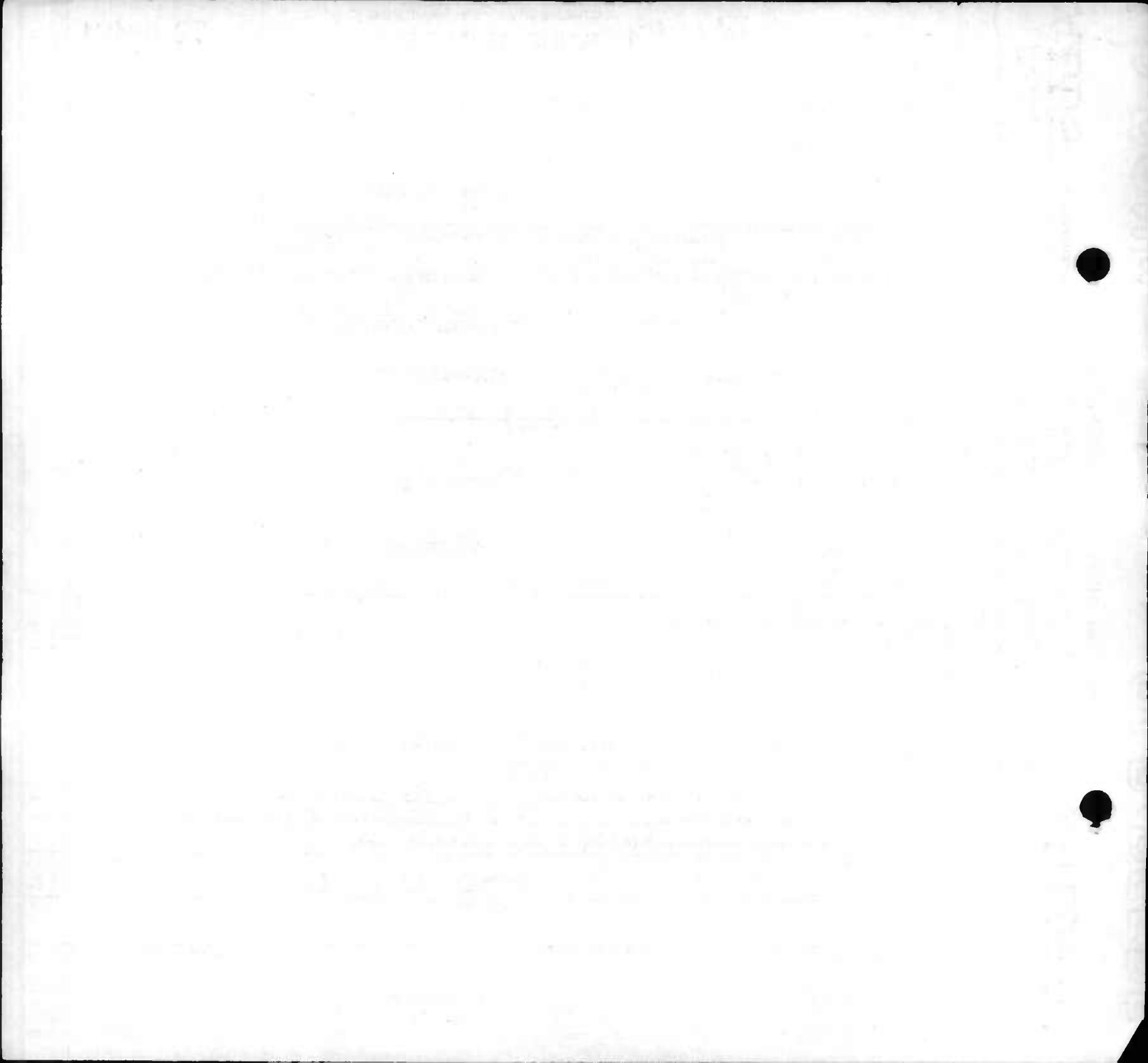




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

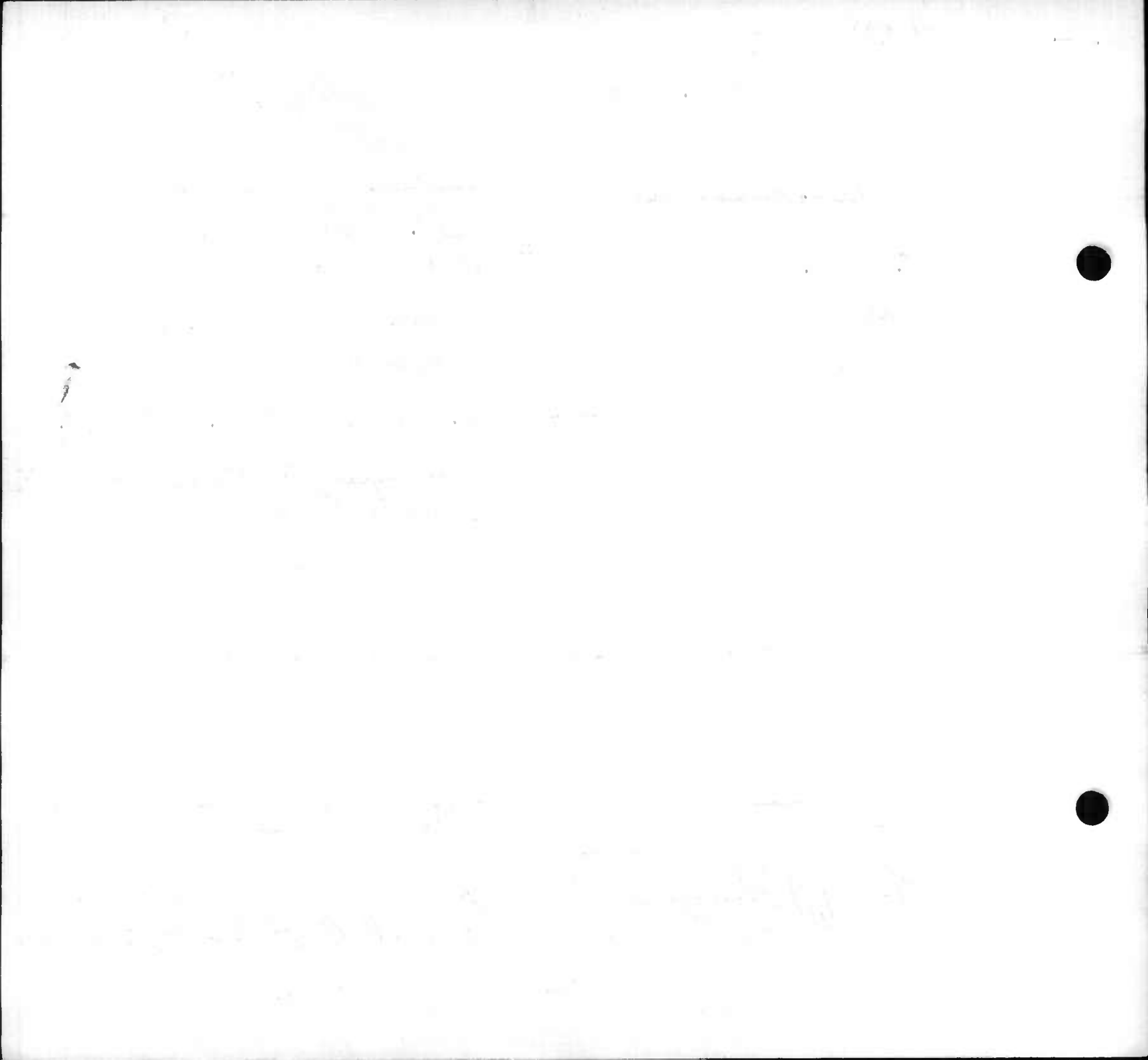
C-516		72 09464		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09464	
BIRTH NO.				STATE OF MARYLAND-DEATH			
1. NAME OF DECEASED (Type or Print) <b>MAMIE CHAMBERS</b>				2. DATE AND HOUR OF DEATH <b>OCTOBER 3 1972 9 25 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>MARYLAND GENERAL HOSPITAL</b>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		A. STATE <b>MARYLAND</b>		B. COUNTY <b>BALTIMORE</b>	
C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <b>4203 Pimlico Rd</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>BLACK</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 23 1910</b>	9. AGE (In years last birthday) <b>62</b>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>BLACK</b>				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b>		16. SOCIAL SECURITY NO. <b>214-16-6114</b>		17. INFORMANT <b>Daughter</b>		ADDRESS <b>4203 Pimlico Rd</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>150X I</b>				CAUSE OF DEATH <b>Respiratory Failure</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Respiratory Failure</b>			
				(B) <b>Bronchitis</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Bronchitis</b>			
				(C) <b>metastasis in liver, pancreas, both kidneys</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				<b>Fractures of Both Femoral Necks</b>			
19A. DATE OF OPERATION <b>MAY 1972</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Ca Bronchus</b>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>No</b>		21B. PLACE OF INJURY i.e., in or about home, farm, factory, street, office bldg, etc.		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <b>August 20 1972</b> to <b>October 3 1972</b> that (1) (we) lost saw the deceased alive on <b>October 2 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Robert A. Cooper MD</b>				23B. DATE SIGNED <b>Oct 3, 1972</b>			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/6/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Arbutus Mem Park</b>		24D. LOCATION (City, town, or county) (State) <b>Woodlawn Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 5 1972</b>		25B. NAME OF REGISTRAR <b>Bridget H. [unclear]</b>		25C. FUNERAL DIRECTOR <b>Alphus Halstead</b>		ADDRESS <b>1206 W North Ave</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09465		REG. NO. 72 09465	
M-600				CERTIFICATE OF DEATH			
BIRTH NO.				STATE OF MARYLAND-DEME			
1. NAME OF DECEASED (Type or Print) <i>Lillian M. Moore</i>				2. DATE AND HOUR OF DEATH <i>October 4, 1972</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>102</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>133 S. Robinson Street</i>				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>133 S. Robinson Street</i>			
5. SEX <i>F.</i>	6. RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4/2/06</i>		9. AGE (In years last birthday) <i>66</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Home</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Penna.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William Moore</i>				14. MOTHER'S MAIDEN NAME <i>Annie Sullivan</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-46-6505</i>		17. INFORMANT ADDRESS <i>Mrs. Ann Crockett 133 S. Robinson St.</i>			
18. <i>15191</i> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <i>Carcinoma of the Stomach</i> 2 months DUE TO, OR AS A CONSEQUENCE OF: <i>C metastasis</i>			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) <del>(the physician)</del> attended the deceased from <i>Nov. 14</i> 1971 to <i>10/4</i> 1972 that (I) <del>(last)</del> last saw the deceased alive on <i>10/3</i> 1972 and that in (my) <del>(own)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(did not)</del> view the body after death.							
23A. SIGNATURE <i>Henry J. Houska MD</i>				23B. DATE SIGNED <i>10/4/72</i>			
23C. PHYSICIAN'S NAME (Type) <i>HENRY J. HOUSKA MD</i>				23D. ADDRESS <i>333 S. East Ave Balto MD 21224</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>10/7/72</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 5 1972</i>				25B. NAME OF REGISTRAR <i>John A. Norton</i>			
				25C. FUNERAL DIRECTOR <i>3000 E. Baltimore St. Baltimore, Md. 21224</i>			



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO.

STATE OF MARYLAND-DHMH

BIRTH NO. <i>W-425</i> <i>72 09466</i>		REG. NO. <i>72 09466</i>	
1. NAME OF DECEASED (Type or Print) <i>WILKINSON, Baby Boy, Barbara</i>		2. DATE AND HOUR OF DEATH <i>9-24-72</i> <i>1.05 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <i>31</i> <i>Baltimore City Hospitals</i> <i>4940 Eastern Ave.</i> <i>Baltimore, Md. 21224</i>		A. STATE <i>Maryland</i> B. COUNTY <i>Wicomico</i>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Parsonsburg</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <i>Male</i> 6. RACE <i>Caucasian</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>9-22-1972</i> 9. AGE (in years lost birthday) <i>-8-</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Norman M. Wilkinson</i>		14. MOTHER'S MAIDEN NAME <i>Barbara Bozman</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>NONE</i>	
17. INFORMANT <i>BCH Records: 4940 Eastern Ave. Baltimore, Md.</i>		ADDRESS	
18. <i>776.2.1</i> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <i>Respiratory arrest.</i> DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>Severe Respiratory distress syndrome</i> DUE TO, OR AS A CONSEQUENCE OF:	
(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>9-24-72</i> to <i>9-24-72</i> that (I) (we) last saw the deceased alive on <i>9-24-72</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Vilma Thitivarana</i>		23B. DATE SIGNED <i>Sept. 24, 1972</i>	
23C. PHYSICIAN'S NAME (Type) <i>VILAIVAN THITIVARANA</i>		23D. ADDRESS <i>4940 Eastern Ave. Baltimore, Md.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>10-4-1972</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Shenhill Memory Gardens</i>		24D. LOCATION (City, town, or county) (State) <i>HEBROW, Wicomico, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 5 1972</i>		25B. NAME OF REGISTRAR <i>Shirley Baker-Bownds, Salisbury Md.</i>	
25C. FUNERAL DIRECTOR ADDRESS			

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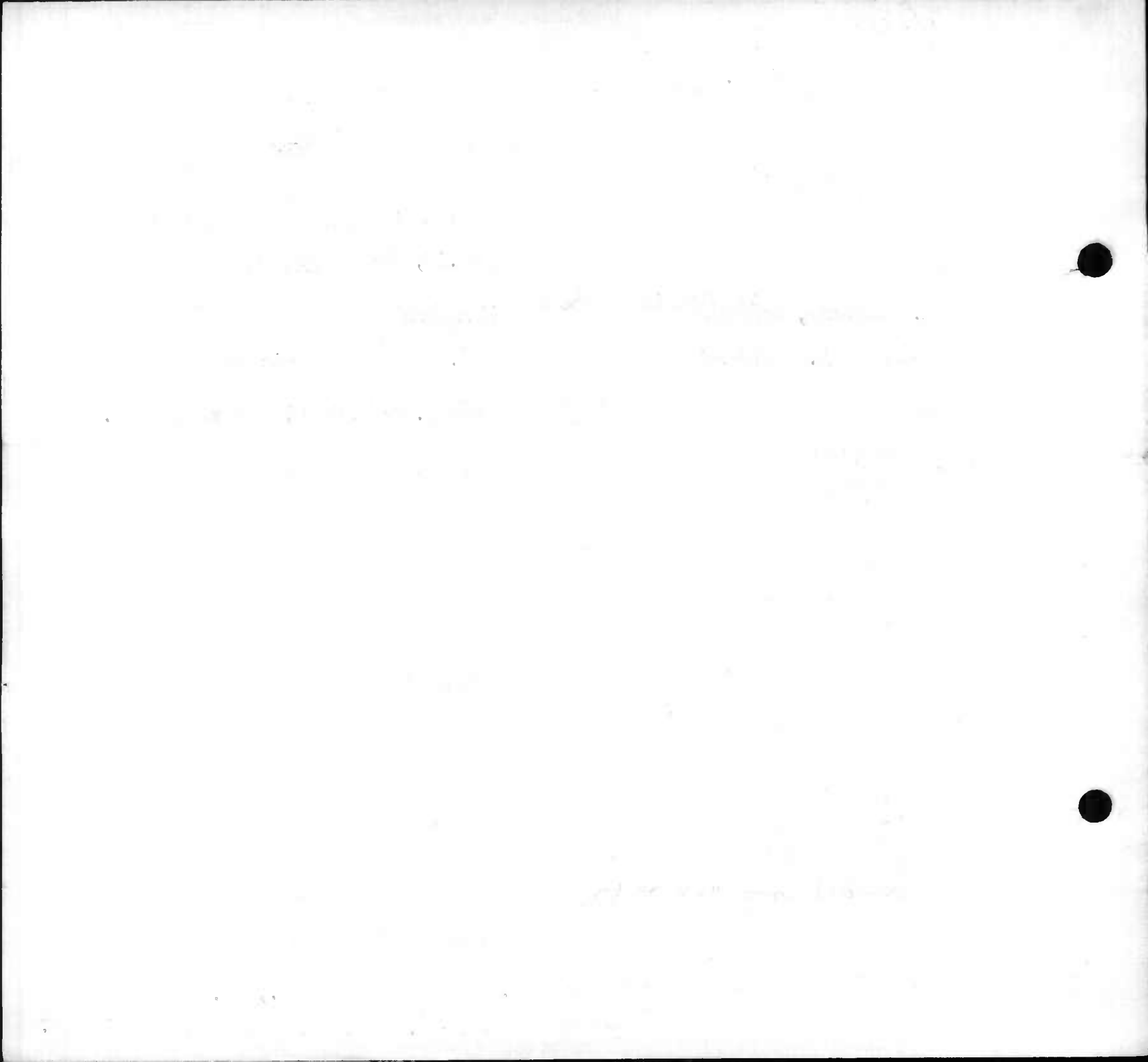
W

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09467	
72 09467				72 09467	
BIRTH NO. <u>H-163</u>		<b>CERTIFICATE OF DEATH</b>		STATE OF MARYLAND	
1. NAME OF DECEASED (Type or Print) <u>Marie J. HABERT</u>		2. DATE AND HOUR OF DEATH <u>10/3/72</u> <u>13:15</u> P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Sinai Hospital of Baltimore</u> <u>Baltimore, Md. Belvedere Greenspring</u> <u>Baltimore, Maryland, 21233</u>		C. CITY OR TOWN <u>Baltimore County</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <u>7112 Queen Anne Rd.</u>					
5. SEX <u>Female</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 23, 1894</u>	9. AGE (In years last birthday) <u>77</u> <u>76</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sec. Treasure, Bookkeeper</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Morris &amp; Eckels</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>John J. Habert</u>			
14. MOTHER'S MAIDEN NAME <u>W. Weichman</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>213 03 7498</u>		17. INFORMANT <u>John J. Habert 7112 Queen Anne Rd.</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Small cell carcinoma</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes!</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>September 6, 1972</u> to <u>October 3, 1972</u> and that (1) (we) last saw the deceased alive on <u>October 3, 1972</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Robert Kroppnick, M.D.</u>		23B. DATE SIGNED <u>10/3/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Robert Kroppnick, M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		24B. DATE <u>10/6/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 5 1972</u>			
25B. NAME OF REGISTRAR <u>Louise W. Horton</u>		25C. FUNERAL DIRECTOR <u>John J. Stansbury 6411 Windsor Mill Rd.</u>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-300		72 09468		BALTIMORE CITY HEALTH DEPARTMENT		72 09468	
CERTIFICATE OF DEATH				REG. NO. <span style="border: 1px solid black; padding: 2px;">72 09468</span>			
BIRTH NO.				DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Walter J. Ruth</b>				30 Sept 72 1745 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		8. COUNTY	
Johns Hopkins Hospital		33		Maryland		Baltimore	
5. SEX				6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Male		Cauc.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country)	
Construction Foreman		Iron Worker Local #16		57		Maryland	
13. FATHER'S NAME				12. CITIZEN OF WHAT COUNTRY?			
Charles Ruth				U.S.A.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
No				213-10-4287		Wife: 2509 Pac Lane Balto. Md. 21219	
18. 011.9 I				CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				Ventilatory Failure 1 month			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: Fibrosis 6 years			
				(C) Pulmonary tuberculosis 12 years			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
28 Sept 72		Ventilatory Failure		Yes		No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
N.A.		N.A.		N.A.			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
N.A.		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		N.A.			
22. I certify that (I) (this hospital) attended the deceased from 2 Sept. 1972 to 30 Sept. 1972, that (I) (we) last saw the deceased alive on 30 Sept. 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Barry L. Zimmerman, M.D.				30 Sept. 72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
BARRY L. ZIMMERMAN				THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		10-4-72		Gardens of Faith Cemetery		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
OCT 5 1972		Andrew...		John J. Duda		7922 Wise Ave. Dundalk, Md.	

3500 The Ave

1011/11 21

Catherine Moore

Charles Ruth

THE BOOKS OF THE BIBLE

BY J. J. L. L. L.

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-255

72 09469

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO.

72 09469

STATE OF MARYLAND - DEPT. OF HEALTH

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Ida Eckman

2. DATE AND HOUR OF DEATH

Sept 30, 1972 11:02 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

31 Baltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

4940 Eastern Avenue 21224

5. SEX

Female

6. RACE

Caucasian

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

9/9/91

9. AGE (In years lost birthday)

58/1

10. Under 1 Yr. Months: Days

11. Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Penna

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Berger

14. MOTHER'S MAIDEN NAME

Catherine Mourey

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

4940 Eastern Avenue ADDRESS

BCH Records Baltimore, Maryland 21224

18. 412.41 + 182.0  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

## CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

① w/o subdural hematoma ② w/o carcinoma of endometrium ③ S/P TAH + BSO 1970

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7-19 1969 to 9-30 1972  
that (I) (we) last saw the deceased alive on 9-30 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Herbert G. Markley M.D.

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

9/30/72

23C. PHYSICIAN'S NAME (Type)

Herbert G. Markley M.D.

23D. ADDRESS

Baltimore City Hospitals 4940 Eastern Avenue  
Baltimore, Md. 21224

24A. BURIAL CREMATION, REMOVAL (Specify)

removal

24B. DATE

Oct 2 1972

24C. NAME OF CEMETERY or CREMATORY

St Johns Cemetery

24D. LOCATION

Scottsdale Pa

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

OCT 5 1972

25B. NAME OF REGISTRAR

Aldrich Funeral Home

25C. FUNERAL DIRECTOR

Aldrich Funeral Home Dundalk Md

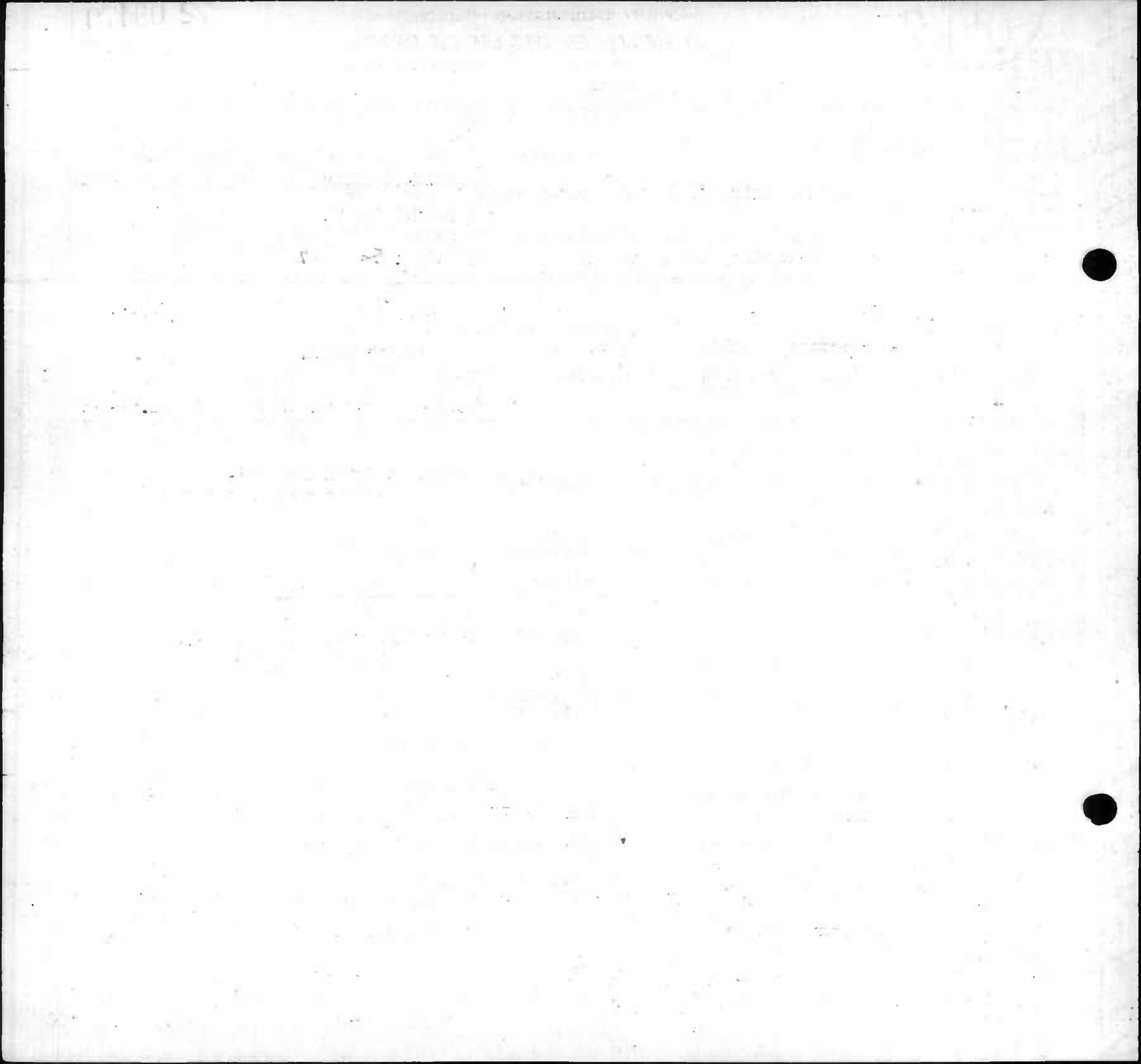
ADDRESS

6702 Bessemer Ave. 21222

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09470		REG. NO. 72 09470	
BIRTH NO. 0-420				72 09470 CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
ELIZABETH Q. OELKE				30 Sept. 1972			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
00 4503 Belair Rd. 21206				Md. 2642			
5. SEX 6. RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 9. AGE (In years last birthday)			
Female Caucasian				31 July 1898 92			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)			
hswf.				Maryland			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
unobtainable William Quarnguesser				unobtainable			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
no							
17. INFORMANT				ADDRESS			
Charles Seymoure, 4503 Belair Rd. 21206							
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				Generalized Arterio-sclerosis, advanced			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II				Carcinoma of breast, postoperative			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED			
				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (XXXXXX) attended the deceased from September ; 1960 to September 28 1972, that (I) (XX) last saw the deceased alive on September 28 1972 and that in (my) (XX) opinion death occurred on the date and hour and from the causes stated above, (I) (XX) (did not) view the body after death.				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
23A. SIGNATURE				23B. DATE SIGNED			
Theodore E. Evans				October 2, 1972			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Theodore E. Evans				9660 Belair Rd. 21236			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE			
Burial				3 Oct 72			
24C. NAME OF CEMETERY OR CREMATORY				24D. LOCATION (City, town, or county) (State)			
Westen Cemetery				Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR			
OCT 5 1972				Sidney Johnson			
25C. FUNERAL DIRECTOR				ADDRESS			
Ulrich Funeral Home, Balto., Md. 21206							





K-100

72 09471

STATE OF MARYLAND  
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 09471

BIRTH NO.

1. NAME OF DECEASED (Type or Print) W. Nina Kopp		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 9 Day 30 Year 72 Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 Union Memorial Hospital		3. DATE PRONOUNCED DEAD Month 9 Day 30 Year 72 Hour 2:10 p. M.	
6. SEX female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH June 10, 1896		10. AGE (In years last birthday) 76	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF USA	
13. FATHER'S NAME W. Preston Jones		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker	
15. MOTHER'S MAIDEN NAME Kate E. Frasier		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No None	
17. SOCIAL SECURITY NO.		18. INFORMANT Family records	
19. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Peter Lipkovic, M.D. EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Oct. 9, 1972	
24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT OCT 5 1972		25B. NAME OF REGISTRAR John Burns' Sons, Towson, Md.	
25C. FUNERAL DIRECTOR John Burns' Sons, Towson, Md.		ADDRESS	

*Handwritten signature*

1  
J-635  
72 09472 STATE OF MARYLAND - DEPT. OF HEALTH  
BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
72 09472  
REG. NO.

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month		Day		Year		Hour			
		Robert Jordan (Jordan)		9		29		72				M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				3. DATE PRONOUNCED DEAD		Month		Day		Year		Hour			
19 N. Howard St.				9		29		72		1:30 p.		M.			
6. SEX				7. RACE				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				C. CITY OR TOWN			
male				White								Balto.			
9. DATE OF BIRTH				10. AGE (In years lost birthday)				11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
12/27/47				24				Md.				U.S.A.			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				14B. KIND OF BUSINESS OR INDUSTRY				15. MOTHER'S MAIDEN NAME				E. STREET AND NUMBER			
Manager				Thomas McCann Store				Bertha Sohn				438 N. Robinson St., Balto. 21224			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				17. SOCIAL SECURITY NO.				18. INFORMANT				ADDRESS			
no				216-50-0548				Bertha Wasielewski (mother)				1			
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
E965X1				Gunshot wound of head											
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:											
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(B) DUE TO, OR AS A CONSEQUENCE OF:											
(C)															
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).															
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No)							
2								yes							
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
				Store				19 N. Howard St.				401			
22D. TIME OF INJURY (APPROX.)				22E. INJURY OCCURRED				22F. HOW DID INJURY OCCUR?							
9 29 72 unk.				WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				Subject shot during hold-up.							
23.				I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				Peter Lipkovic, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED			
EXAMINER'S NAME (Type)								ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				9/30/72			
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>															
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE				24C. NAME of CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)			
Burial				10/4/72				Oak Lawn Cemetery				Balto. Md.			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR				ADDRESS			
OCT 5 1972				Sidney A. [Signature]				Schimunek Funeral Homes, Inc.				3331 Brehms Lane, Balto. Md. 21213			

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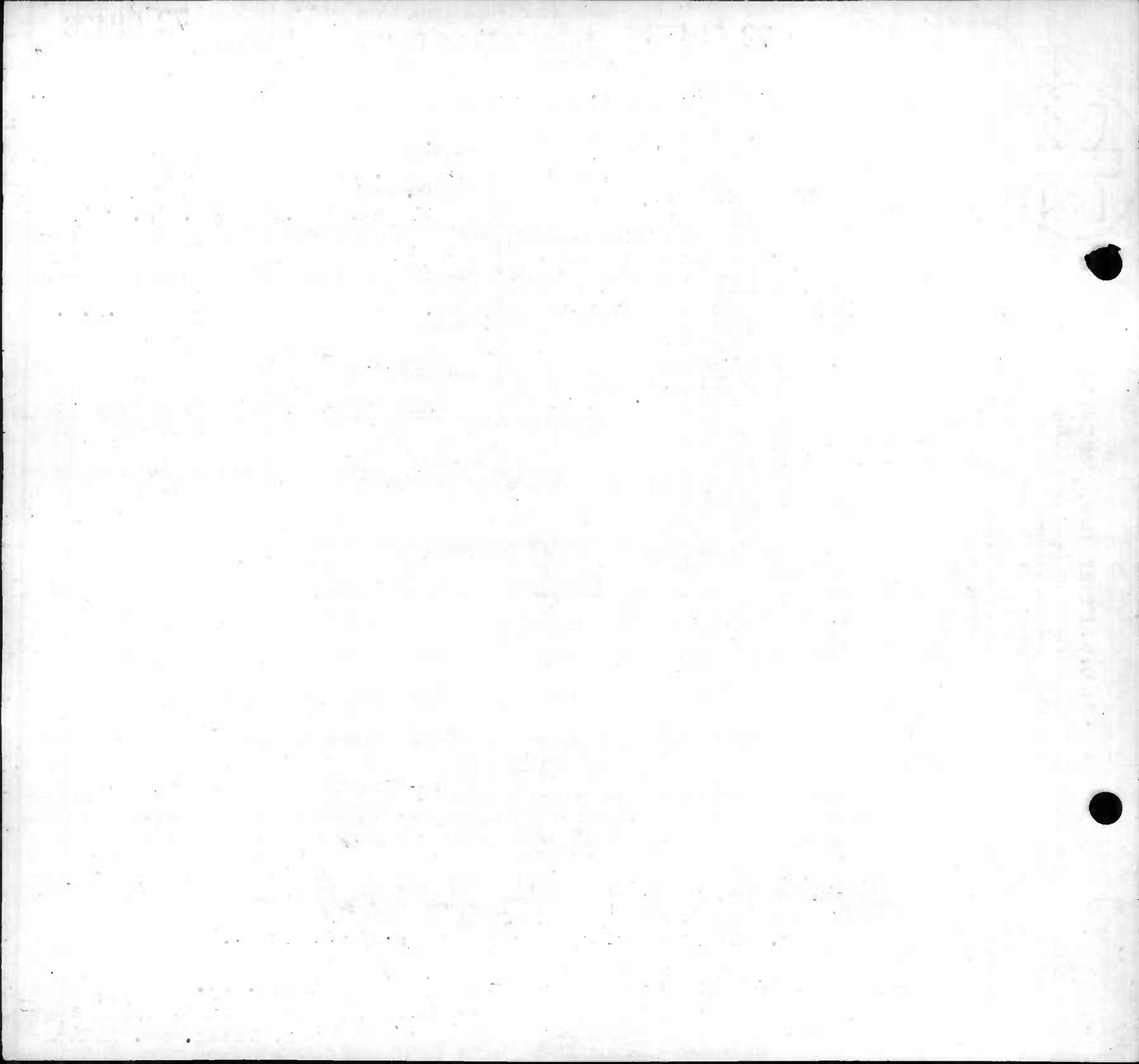
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09473		72 09473	
BIRTH NO.				72 09473		STATE OF MARYLAND-DHME	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Caroline L. Barnes				9/30/72 6 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  00 2844 Lake Ave.				A. STATE		B. COUNTY	
				Md.		831	
5. SEX				6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
F				W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
housewife				at home		Md.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Charles Lovell				Caroline Himmel			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
no				215-32-3985		Paul Barnes (husband) same as above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE		3 mos.	
				DUE TO, OR AS A CONSEQUENCE OF:			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examined)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 1947 to 9-30-72, that (I) last saw the deceased alive on 9-29-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Dr. William Fearing				10-3-72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Dr. William Fearing				3025 Belair Rd.			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial				10/3/72		Parkwood Cemetery	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME of REGISTRAR		25C. FUNERAL DIRECTOR	
OCT 5 1972				Schimunek Funeral Homes, 3331 Brehms Lane, Balto. Md. 21213		Schimunek Funeral Homes, 3331 Brehms Lane, Balto. Md. 21213	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Marie Jordan (Jordan)</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>9 29 72</b> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>19 N. Howard St.</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>9 29 72 1:30 p.</b> M.			
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>601</b>							
6. SEX <b>female</b>	7. RACE <b>White</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>11/14/29</b>		10. AGE (In years last birthday) <b>42</b>		E. STREET AND NUMBER <b>438 N. Robinson St., Balto. 21224</b>			
11. BIRTHPLACE (State or foreign country) <b>Penn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Harold Kling</b>			
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Balto. SportsWear</b>		15. MOTHER'S MAIDEN NAME <b>Elvira Letteer</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO. <b>209-24-5434</b>		18. INFORMANT ADDRESS <b>Bertha Wasielewski )mother-in-law</b>			
MEDICAL CERTIFICATION 19. <b>E965X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH <b>Gunshot wound of head</b>			
				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) <b>yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Store</b>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>19 N. Howard St.</b> <b>401</b>			
22D. TIME OF INJURY (APPROX.) <b>9 29 72 unk.</b>		22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Subject shot during hold-up.</b>			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Peter Lipkovic, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>9/30/72</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/4/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 5 1972</b>		25B. NAME OF REGISTRAR <b>Adolph...</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md 21213</b>			



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## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO.

72 09475

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Terzie Johnson

2. DATE AND HOUR OF DEATH

10/2/72

1 326

P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE Baltimore

B. COUNTY Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

524 S. Baldwin St.

5. SEX

Female

6. RACE

Caucasian

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

6/01/02

9. AGE (In years last birthday)

70

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

at Home

11. BIRTHPLACE (State or foreign country)

Penn.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

unknown

14. MOTHER'S MAIDEN NAME

Dollie Madison

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

228-03-8506

17. INFORMANT

Baltimore City Hospitals  
4940 Eastern Avenue  
Lillian Cagan Daughton

ADDRESS

Balto., Md. 21224

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cardiac Arrest

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

30 minutes

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Atherosclerotic Cardiovascular Disease

1 1/2 years

(C)

## MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A)

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from 10/2/72 3 PM 19 72 to 10/2/72 3 26 PM 19 72 that (1) (we) last saw the deceased alive on 10/2 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Roscoe Friedman MD

DEGREE

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

10/2/72

23C. PHYSICIAN'S NAME (Type)

Roscoe Friedman

DEGREE

23D. ADDRESS

Baltimore City Hospitals

4940 Eastern Ave. Balto., Md. 21224

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

10/6/72

24C. NAME OF CEMETERY or CREMATORY

Balto. National Cemetery

24D. LOCATION

(City, town, or county)

(State)

Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.

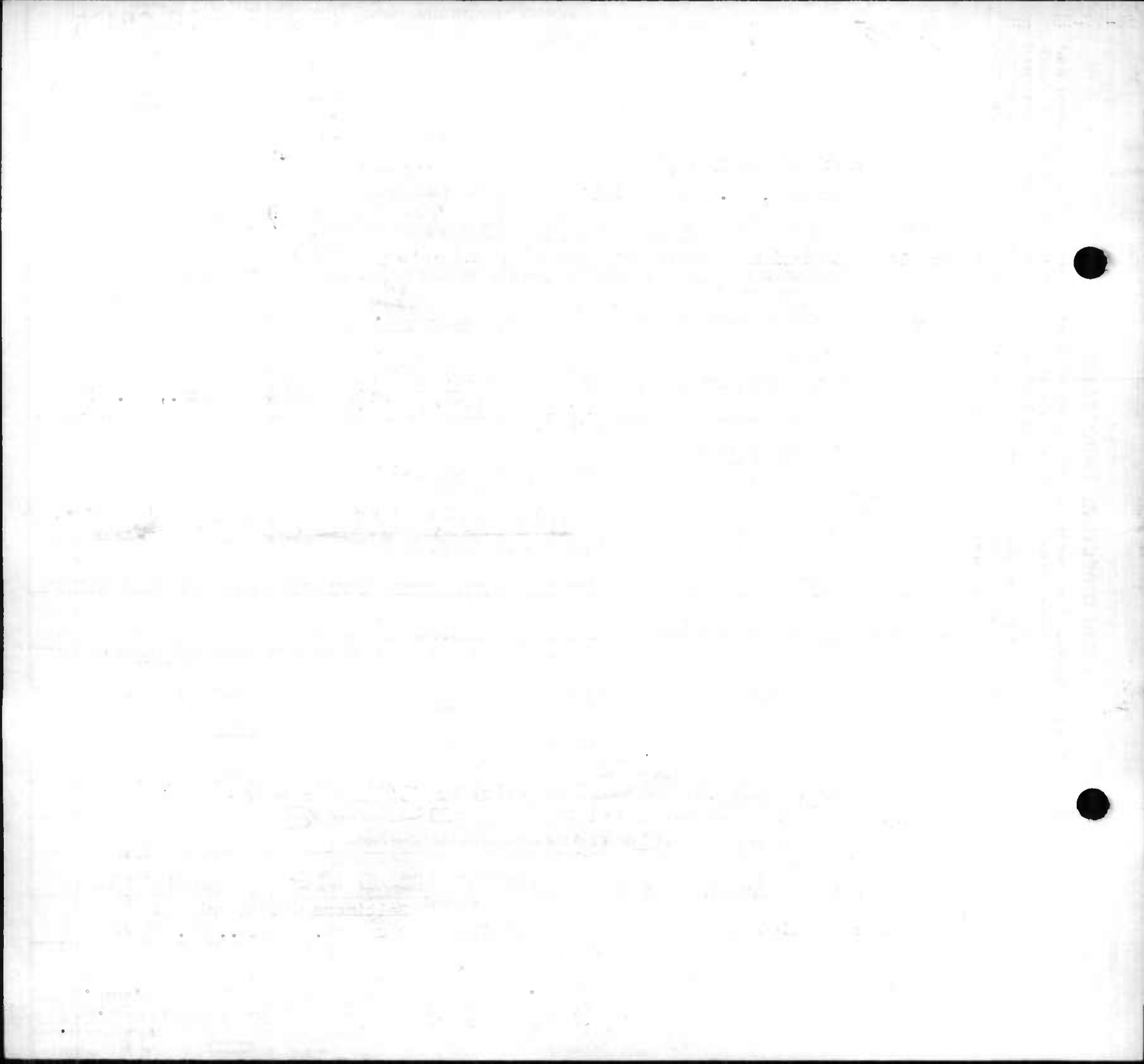
OCT 5 1972

25B. NAME OF REGISTRAR

A. J. Schimmuck

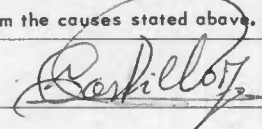
25C. FUNERAL DIRECTOR

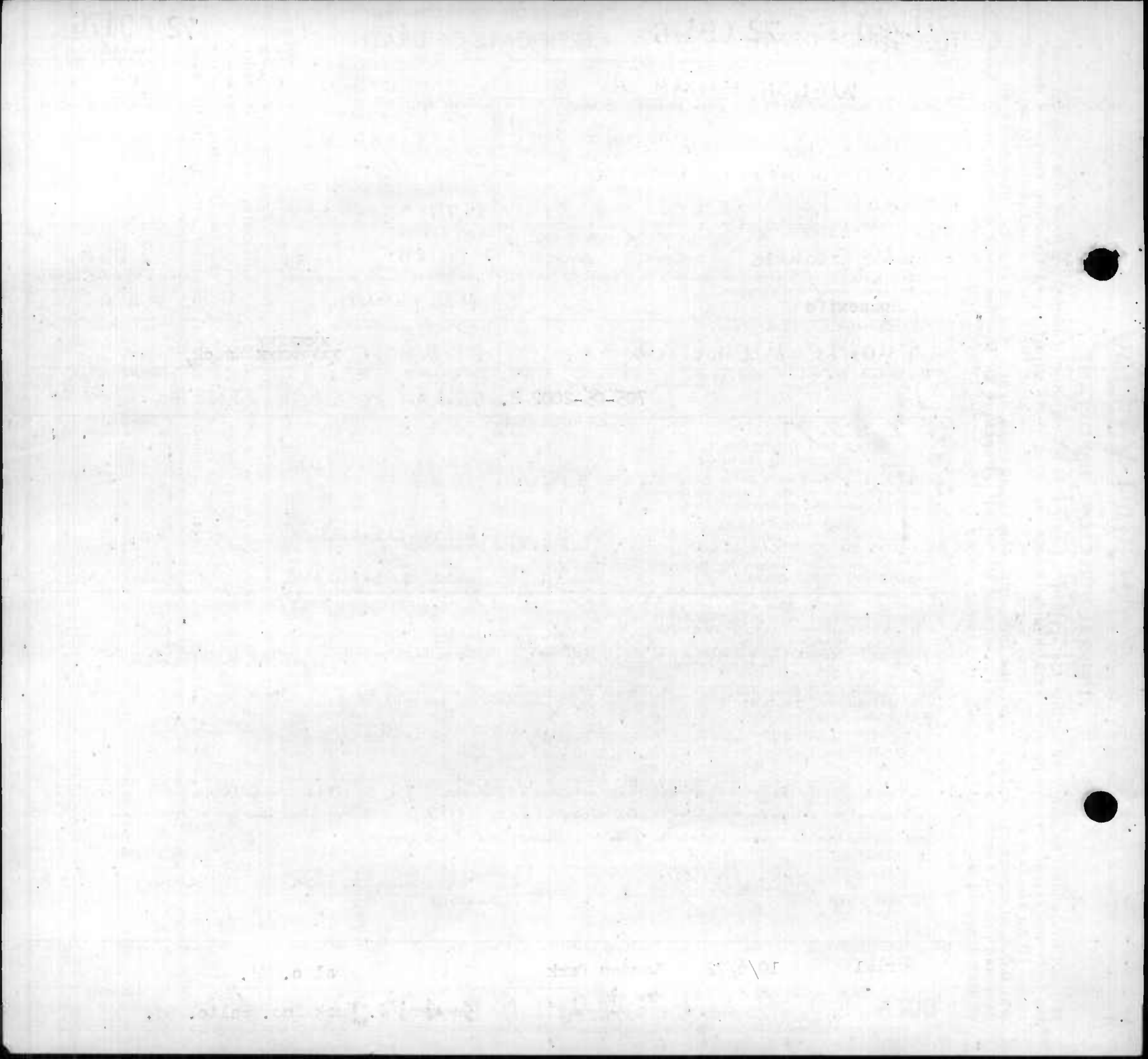
Schimmuck Funeral Homes, Inc. 3331 Brehms Lane, Balto., MD



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09476		72 09476	
BIRTH NO. 11-420				72 09476		REG. NO. 72 09476	
CERTIFICATE OF DEATH				STATE OF MARYLAND - DEPT.			
1. NAME OF DECEASED (Type or Print) <b>WELSH, EMMA A.</b>				2. DATE AND HOUR OF DEATH <b>10-3-72, 7:35 a.m.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2643</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>THE Union Memorial Hospital</b> <b>44</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>3779 Ravenwood Avenue</b>			
5. SEX <b>Female</b>	6. RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-1-1891</b>	9. AGE (In years last birthday) <b>81</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>THOMAS MILHOLLAND</b>				14. MOTHER'S MAIDEN NAME <b>ELIZABETH <del>XXXXXX</del> Hauck</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>705-05-2002 B.</b>		17. INFORMANT <b>WILLIAM J. WELSH</b>		
					ADDRESS <b>3779 Ravenwood Avenue</b>		
18. <b>250.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>13 hrs.</b>			
(A) IMMEDIATE CAUSE <b>Cerebral thrombosis.</b> DUE TO, OR AS A CONSEQUENCE OF:							
(B) <b>Atherosclerosis.</b> DUE TO, OR AS A CONSEQUENCE OF:							
(C) <b>Diabetes mellitus.</b>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>September 14</b> 1972 to <b>October 3</b> 1972, that (I) ( <del>we</del> ) last saw the deceased alive on <b>October 2</b> 1972 and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.							
23A. SIGNATURE 				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>October 3 1972.</b>	
23C. PHYSICIAN'S NAME (Type) <b>DEGREE</b>				23D. ADDRESS <b>DEGREE</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/6/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 5 1972</b>		25B. NAME OF REGISTRAR <b>Leonard J. Buck Inc.</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Buck Inc.</b>		ADDRESS <b>Balto. Md.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
7-430 72 09477 CERTIFICATE OF DEATH					REG. NO. 72 09477				
STATE OF MARYLAND-DEPT									
1. NAME OF DECEASED (Type or Print) <u>Charles Howard Floyd</u>					2. DATE AND HOUR OF DEATH <u>10 / 3 / 72 11:28 P.M.</u>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <u>South Baltimore General Hosp</u>					A. STATE <u>Maryland</u> B. COUNTY <u>BALTO</u>				
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					C. CITY OR TOWN <u>Baltimore</u>				
<u>43</u>					D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
E. STREET AND NUMBER <u>118 Poplar Rd.</u>									
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/5/12</u>	9. AGE (In years lost birthday) <u>60</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Web Pressman</u>					10B. KIND OF BUSINESS OR INDUSTRY <u>News American Newspaper</u>				
11. BIRTHPLACE (State or foreign country) <u>Balto. Md</u>					12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>Howard Floyd</u>					14. MOTHER'S MAIDEN NAME <u>Emma Fisher</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> <u>WWII</u>					16. SOCIAL SECURITY NO. <u>215-03-6410</u>				
17. INFORMANT <u>Hospital Chart</u>					ADDRESS				
18. <u>571.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
(A) IMMEDIATE CAUSE <u>Renal shutdown &amp; Azotemia</u>					<u>14 hrs</u>				
(B) <u>Hypovolemic shock</u>					<u>1 day</u>				
(C) <u>Hepatic failure, cirrhosis</u>					<u>wk</u>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>COPD</u>					<u>years</u>				
19A. DATE OF OPERATION <u>1 9/27/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>cholelithiasis</u>			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>no</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>X</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>9/19</u> 19 <u>72</u> to <u>10/3</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>10/3</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Stanford J. Huber MD</u>					23B. DATE SIGNED <u>10/3/72</u>			23C. PHYSICIAN'S NAME (Type) <u>Stanford J. Huber MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>					24B. DATE <u>10-7-72</u>			24C. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>	
24D. LOCATION <u>Balto., Md. 21234 4</u>					25A. DATE REC'D BY HEALTH DEPT. <u>OCT 5 1972</u>				
25B. NAME OF REGISTRAR <u>Leonard J. Ruck, Inc.</u>					25C. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc., 5305 Harford Rd.</u>				

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Page 2 of 2

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STATE OF MARYLAND - DEPT. OF HEALTH  
BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
BIRTH NO. 72-12162  
REG. NO. 72 09478

1. NAME OF DECEASED (Type or Print) <b>Tammie Whorton</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>9 30 72</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>1436 S. Hanover St. 2-23-72</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>9 30 72 8:00 a.</b>	
6. SEX <b>female</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>8/19/72</b>		10. AGE (In years last birthday) <b>6 wks</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>baby</b>	
15. MOTHER'S MAIDEN NAME <b>Sharon Whorton</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS <b>Sharon Whorton, 1436 S. Hanover St. Balt. Md.</b>	
19. CAUSE OF DEATH <b>Acute myocarditis, Sudden death in infancy interstitial</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b> EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/3/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Glendale Brethern Cemetery</b>		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 5 1972</b>		25B. NAME OF REGISTRAR <b>Sharon Whorton</b>	
25C. FUNERAL DIRECTOR <b>Hafer Funeral Service, 1302 Nat. Hwy. LaVale Md.</b>		ADDRESS	

2-23-1973 - Letter from the Office of the Chief Medical Examiner, Peter Lipkovic, M.D.  
Assistant Medical Examiner hs

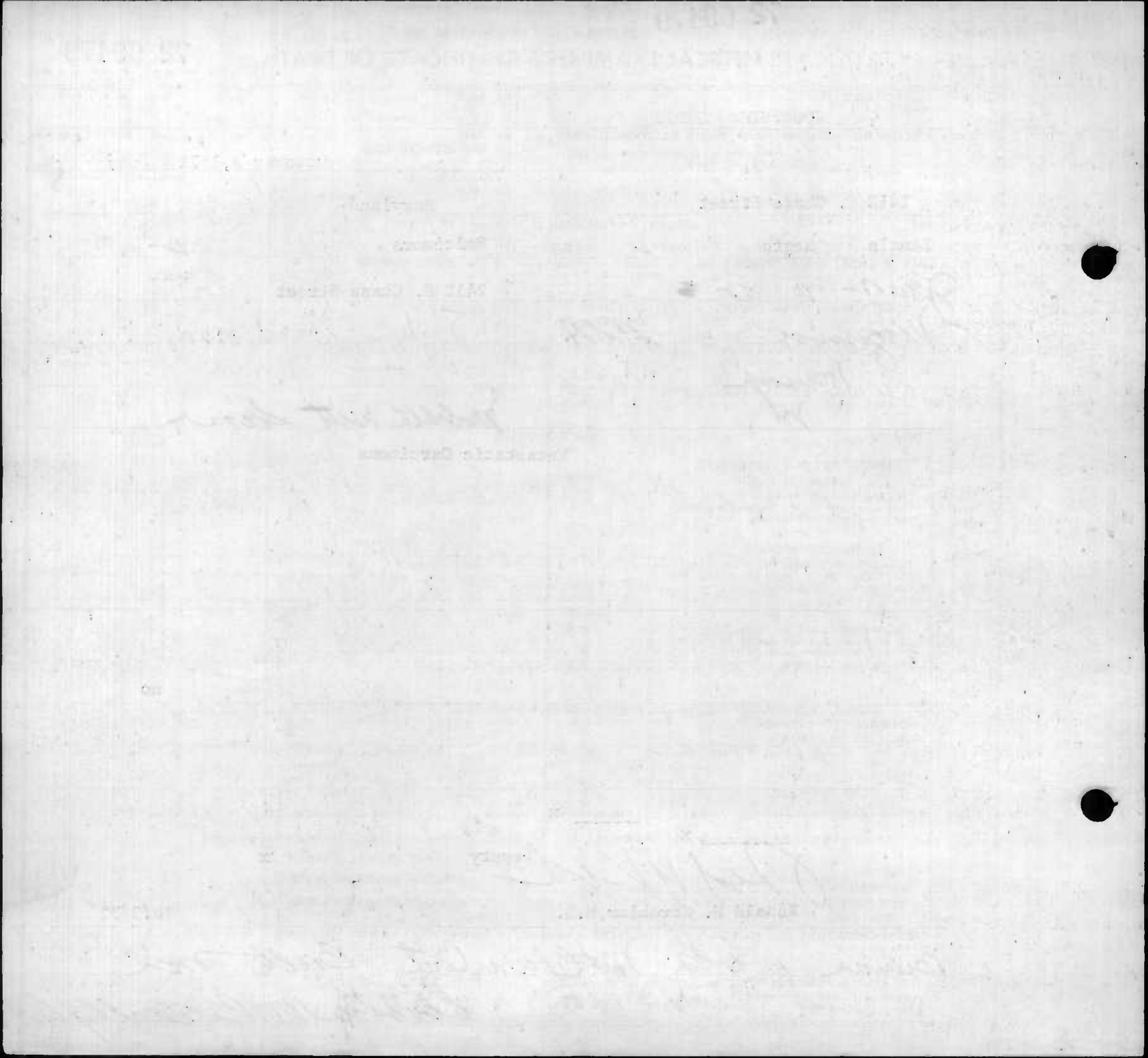
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 09479

BIRTH NO.

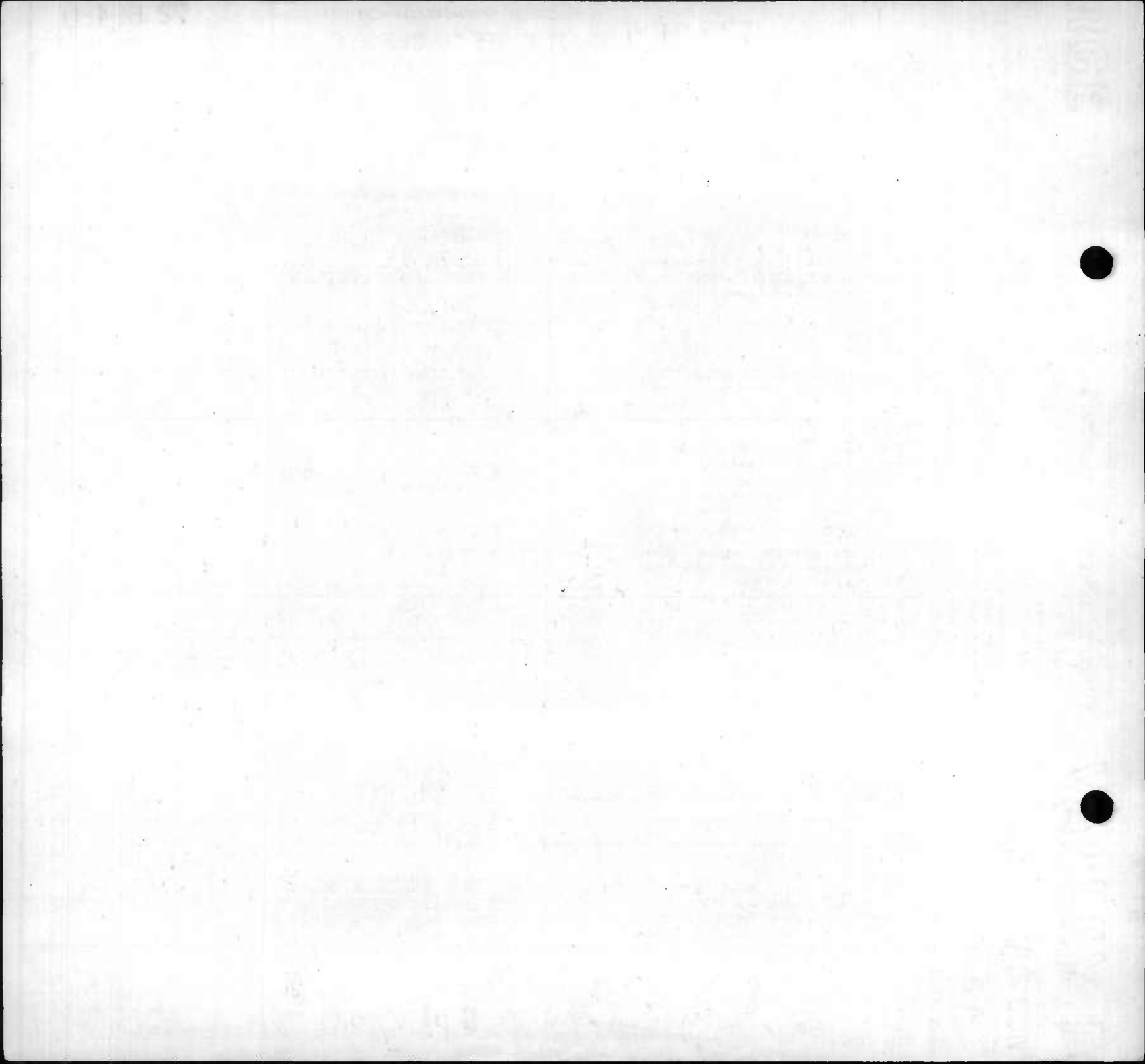
1. NAME OF DECEASED (Type or Print) <b>JOSEPHINE GROSS</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>200 2412 E. Chase Street</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>October 3, 1972 8:20 A. M.</b>	
6. SEX <b>Female</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>Jan 7 - 1890</b>		10. AGE (In years last birthday) <b>82</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Goodman</b>		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>833</b>	
15. MOTHER'S MAIDEN NAME <b>None</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b>	
17. SOCIAL SECURITY NO.		18. INFORMANT <b>Michael Witt</b>	
19. <b>199.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Metastatic Carcinoma</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION <b>10-6-72</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>no</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE: <b>Ronald N. Kornblum, M.D.</b> DATE SIGNED: <b>10/3/72</b> EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-6-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Intoburn Cent</b>		24D. LOCATION (City, town, or county) (State) <b>Balto Md</b>	
25A. DATE REC'D BY HEALTH DEPT <b>OCT 5 1972</b>		25B. NAME OF REGISTRAR <b>Adolphus</b>	
25C. FUNERAL DIRECTOR <b>Edwin 1000 Broadway</b>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 09480</u>
72 09480 CERTIFICATE OF DEATH				STATE OF MARYLAND-DEATH
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Frances Morris</u>		
2. DATE AND HOUR OF DEATH <u>9/29/72</u> <u>5 12</u> P. M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>402</u>		FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>38 University of Maryland</u> <u>Lombard &amp; Greene St</u>		
C. CITY OR TOWN <u>Balt.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <u>767 W. Fairmount Ave.</u>				
S. SEX <u>F</u>	6. RACE <u>Black</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>2/10/12</u>	9. AGE (In years last birthday) <u>60</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>-</u>		
14. MOTHER'S MAIDEN NAME <u>Mary Hall</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>213-18-3274</u>		17. INFORMANT <u>Vivian L. Imes</u>		
18. CAUSE OF DEATH <u>590.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Chronic pyelonephritis many years.</u>		ADDRESS <u>109 N. Carlton St.</u>		
MEDICAL CERTIFICATION				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>Sept. 1</u> 19 <u>72</u> to <u>Sept.</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>Sept 27</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Robert E. Greenspan MD</u> DEGREE				23B. DATE SIGNED <u>9/29/72</u>
23C. PHYSICIAN'S NAME (Type) <u>Robert E. Greenspan</u> DEGREE				23D. ADDRESS
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>10-4-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>MT. ARIAN CEM.</u>
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>OCT 5 1972</u>		
25B. NAME OF REGISTRAR <u>Anthony Wilson</u>		25C. FUNERAL DIRECTOR <u>Anthony Wilson</u>		
25D. ADDRESS <u>1000 Brimley Ave.</u>				





H-620

72 09481

BALTIMORE CITY HEALTH DEPARTMENT

72 09481

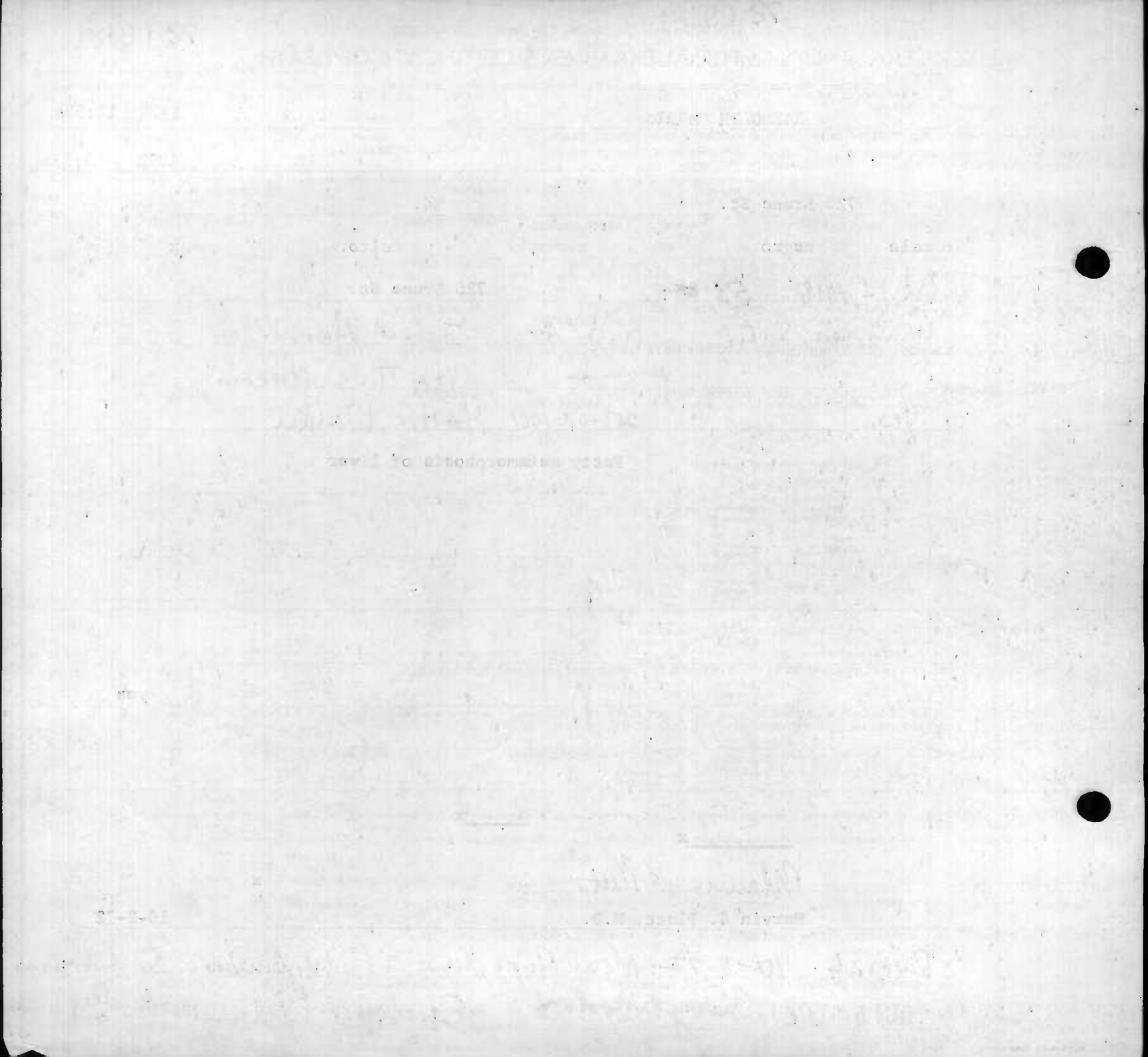
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>RANDOLPH HARRIS</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>10 1 1972 11:55a</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 726 Brune St.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>10 1 1972 11:55a</b>	
6. SEX <b>male</b>		7. RACE <b>negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>Oct. 12, 1918</b>		10. AGE (In years, last birthday) <b>54</b>	
11. BIRTHPLACE (State or foreign country) <b>W. Winstboro, S. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes</b>		17. SOCIAL SECURITY NO. <b>251-67-1461</b>	
18. INFORMANT <b>Hattie Walker</b>		ADDRESS	
19. CAUSE OF DEATH <b>571.81</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Fatty metamorphosis of liver</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(A) IMMEDIATE CAUSE</b> DUE TO, OR AS A CONSEQUENCE OF: <b>(B)</b> DUE TO, OR AS A CONSEQUENCE OF: <b>(C)</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Min.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) <b>yes</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <b>Marvin S. Platt</b> M.D. EXAMINER'S NAME (Type) <b>Marvin S. Platt, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>10-2-72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10-8-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>New Hope, C.</b>		24D. LOCATION (City, town, or county) (State) <b>W. Winstboro, S. Carolina</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 5 1972</b>		25B. NAME OF REGISTRAR <b>Sidney [Signature]</b>	
25C. FUNERAL DIRECTOR <b>Edgar O. Wilson</b>		ADDRESS <b>1000 Brantley</b>	

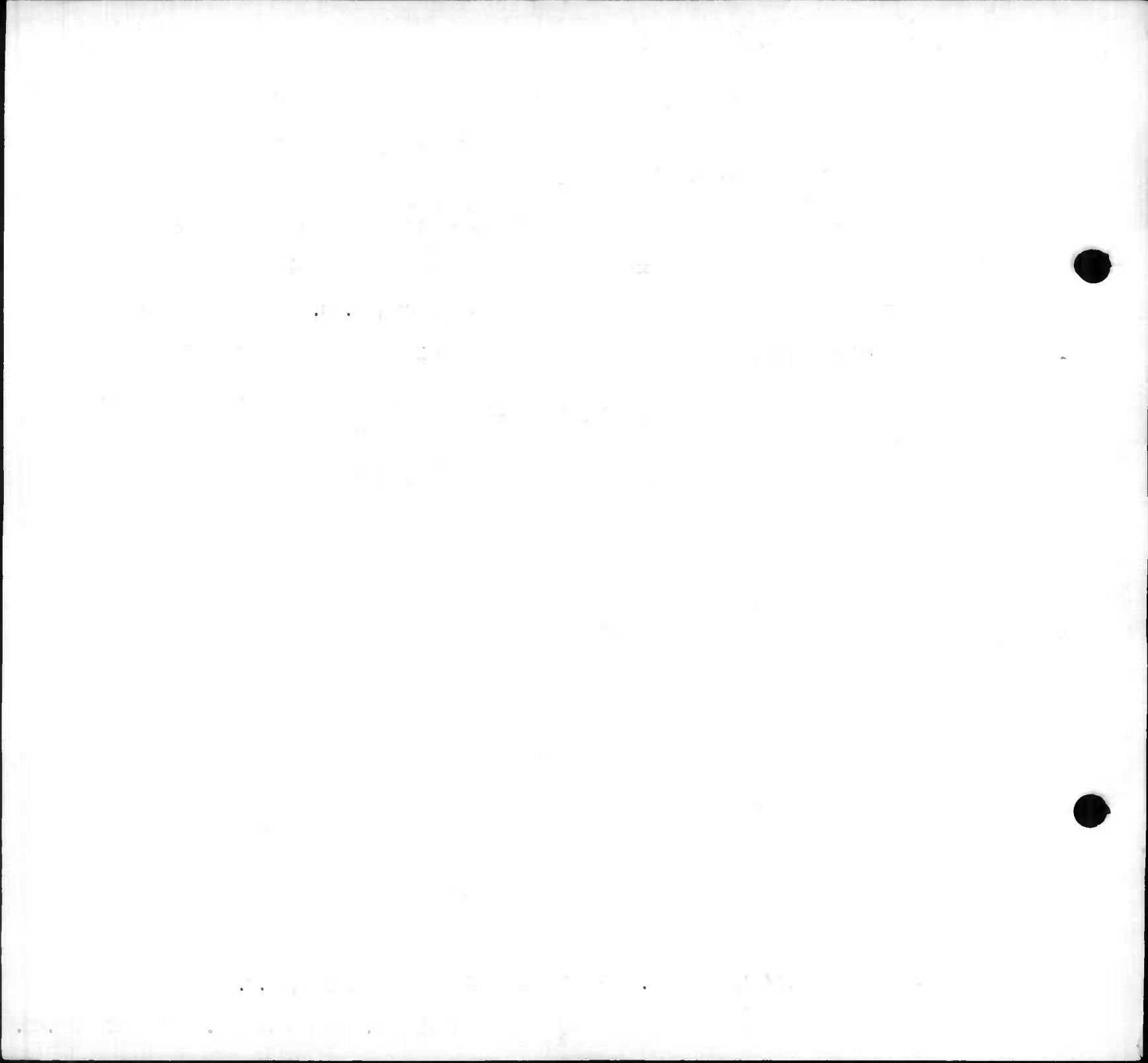




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 09482		REG. NO. 72 09482	
G-660		72 09482		STATE OF MARYLAND-DEMD	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Grier, Lewis Excel</i>		2. DATE AND HOUR OF DEATH <i>10-4-72 12:10 AM</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>802</i>		C. CITY OR TOWN <i>BALTO.</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Duke Land Nursing Home</i> <i>1501 N. Duke Land St.</i>		E. STREET AND NUMBER <i>2230 E. North Ave.</i>			
5. SEX <i>m</i>	6. RACE <i>N</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/88</i>	9. AGE (In years last birthday) <i>83</i>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>CHARLOTTE, N. C.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>MORRIS GRIER</i>		14. MOTHER'S MAIDEN NAME <i>MOLLIE UNKNOWN</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>212-34-6634</i>		17. INFORMANT <i>Duke Land Nursing Home</i> ADDRESS <i>1501 N. Duke Land St.</i>	
18. <i>412.41</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <i>ASCVD.</i> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>34RS.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>1-15-</i> <i>1971</i> to <i>10-4-</i> <i>1972</i> that (I) (we) last saw the deceased alive on <i>10-4-</i> <i>1972</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Percival C. Smith</i>		23B. DATE SIGNED <i>10-4-72</i>		23C. PHYSICIAN'S NAME (Type)	
23D. ADDRESS		23E. NAME OF REGISTRAR		23F. FUNERAL DIRECTOR <i>WILLIAM J. SPICER</i>	
23G. ADDRESS		23H. ADDRESS		23I. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>10/8/72</i>		24C. NAME of CEMETERY or CREMATORY <i>MT. OLIVET CEMETARY</i>	
24D. LOCATION (City, town, or county) (State) <i>DIXIE, N.C.</i>		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
24G. DATE REC'D BY HEALTH DEPT. <i>OCT 5 1972</i>		24H. NAME OF REGISTRAR <i>William J. Spicer</i>		24I. FUNERAL DIRECTOR <i>WILLIAM J. SPICER</i>	
24J. ADDRESS <i>1639 N. BROADWAY BALT. MD.</i>		24K. ADDRESS		24L. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09483	
72 09483				STATE OF MARYLAND-DMH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		JOHN ANTHONY MANNING		OCT 4 1972 8:30 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION BALT. MORE CITY HOSPITAL			A. STATE MARYLAND		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 111 S EAST AVE 21224		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 28 1913	9. AGE (In years last birthday) 59	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OFFICE CLERK		10B. KIND OF BUSINESS OR INDUSTRY ST MICHAEL'S CHURCH		11. BIRTHPLACE (State or foreign country) LYNCHBURG, VA.	
12. CITIZEN OF WHAT COUNTRY? USA.		13. FATHER'S NAME WILLIAM MANNING			
14. MOTHER'S MAIDEN NAME MARGARET LAWLESS		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 215-10-8260		17. INFORMANT DOROTHY MANNING 111 S EAST AVE			
18. 410.9 14 250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). DIABETES MELLITUS		CAUSE OF DEATH (A) IMMEDIATE CAUSE MYOCARDIAL INFARCTION INSTANTANEOUS DUE TO, OR AS A CONSEQUENCE OF: (B) ARTERIOSCLEROTIC C.V. DISEASE 1 YR. DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/12 1967 to 10/4 1972, that (I) <del>last</del> saw the deceased alive on 9/22 1972 and that in (my) <del>last</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>did not</del> (did not) view the body after death.					
23A. SIGNATURE Henry J. Houska MD				23B. DATE SIGNED 10/4/72	
23C. PHYSICIAN'S NAME (Type) HENRY J HOUSKA MD				23D. ADDRESS 333 S EAST AVENUE BALTO MD	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE OCT 7 1972		24C. NAME OF CEMETERY or CREMATORY HOLY REDEEMER CEM.	
24D. LOCATION (City, town, or county) (State) BALTO MD		24E. FUNERAL DIRECTOR DIPPEL BRAS INC 1800 E LOMBARD ST			
25A. DATE REC'D BY HEALTH DEPT. OCT 5 1972		25B. NAME OF REGISTRAR Audrey H. [Signature]		25C. ADDRESS	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 09484

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Larry L. Skinner

2. DATE OF DEATH Known ☒ Estimated ☐ Month Day Year Hour  
9 29 72 M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF HOSPITAL OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

40 St. Agnes Hospital

3. DATE PRONOUNCED DEAD Month Day Year Hour  
9 29 72 12:30 p. M.5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Md. B. COUNTY 1510

6. SEX

male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☐ NO ☐

9. DATE OF BIRTH

4/15/46

10. AGE (In years  
last birthday)

26

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

4103 Belle Ave

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Wallace Skinner

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Sailor

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Barbara Sullivan

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

18. INFORMANT

Patricia Skinner 4103 Belle Ave

ADDRESS

19. E 9884

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Craniocerebral injuries

(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

Bronchopneumonia

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☒ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)  
Alley22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?  
unk.22D. TIME OF INJURY (Month) (Day) (Year) (Hour)  
(APPROX.) 9 22 72 unk m.22E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE  
AT WORK ☒22F. HOW DID INJURY OCCUR?  
unk.

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Peter Lipkovic, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED  
9/30/7224A. BURIAL CREMATION,  
REMOVAL (Specify)

Removal

24B. DATE

10/6/72

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county) (State)

Halifax, N.C.

25A. DATE REC'D BY HEALTH DEPT.

OCT 5 1972

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

N 854.0

Miss Emily  
Miss Mary  
Miss John  
Miss William

4/2/16  
Miss Mary  
Miss John  
Miss William

General Manager

General Manager

Miss Mary

Miss John

Miss William

Miss Emily

General Manager

4/2/16

Miss Mary

Miss John



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 09485

BIRTH NO.

STATE OF MARYLAND-DEME

1. NAME OF DECEASED (Type or Print) <b>JOHN WHITE</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1837 N. Chester Street</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>October 3, 1972 8:36 A.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>2-3-19</b>		10. AGE (In years last birthday) <b>53</b>	
11. BIRTHPLACE (State or foreign country) <b>VA.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Mary Joyce</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	
15. MOTHER'S MAIDEN NAME <b>MARY JOYCE.</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO. <b>215-09-1317</b>		18. INFORMANT <b>Ethel STAINBACK</b>	
19. <b>412.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>No</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE: <b>Ronald N. Kornblum</b> M.D. EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/7/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>mt. Calvary</b>		24D. LOCATION (City, town, or county) (State) <b>G.A. County Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 5 1972</b>		25B. NAME OF REGISTRAR <b>Sidney B. ...</b>	
25C. FUNERAL DIRECTOR <b>Joseph B. Lock</b>		ADDRESS <b>1304 N. Central Ave</b>	

100-2-10

Wm. J. Fox

Wm. J. Fox

Wm. J. Fox

Wm. J. Fox

Wm. J. Fox

20

Wm. J. Fox

Wm. J. Fox

Wm. J. Fox

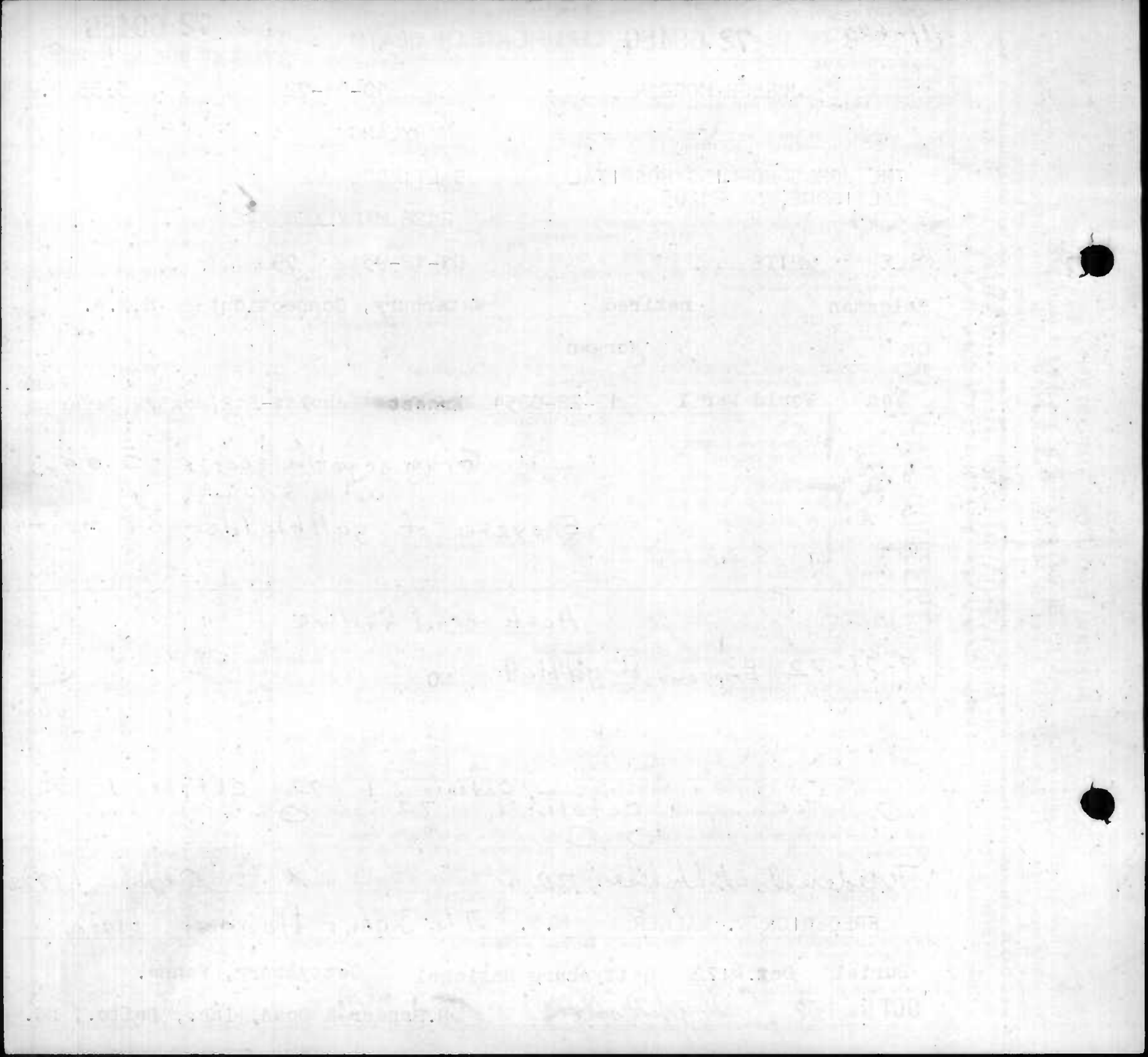
Wm. J. Fox

Wm. J. Fox

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

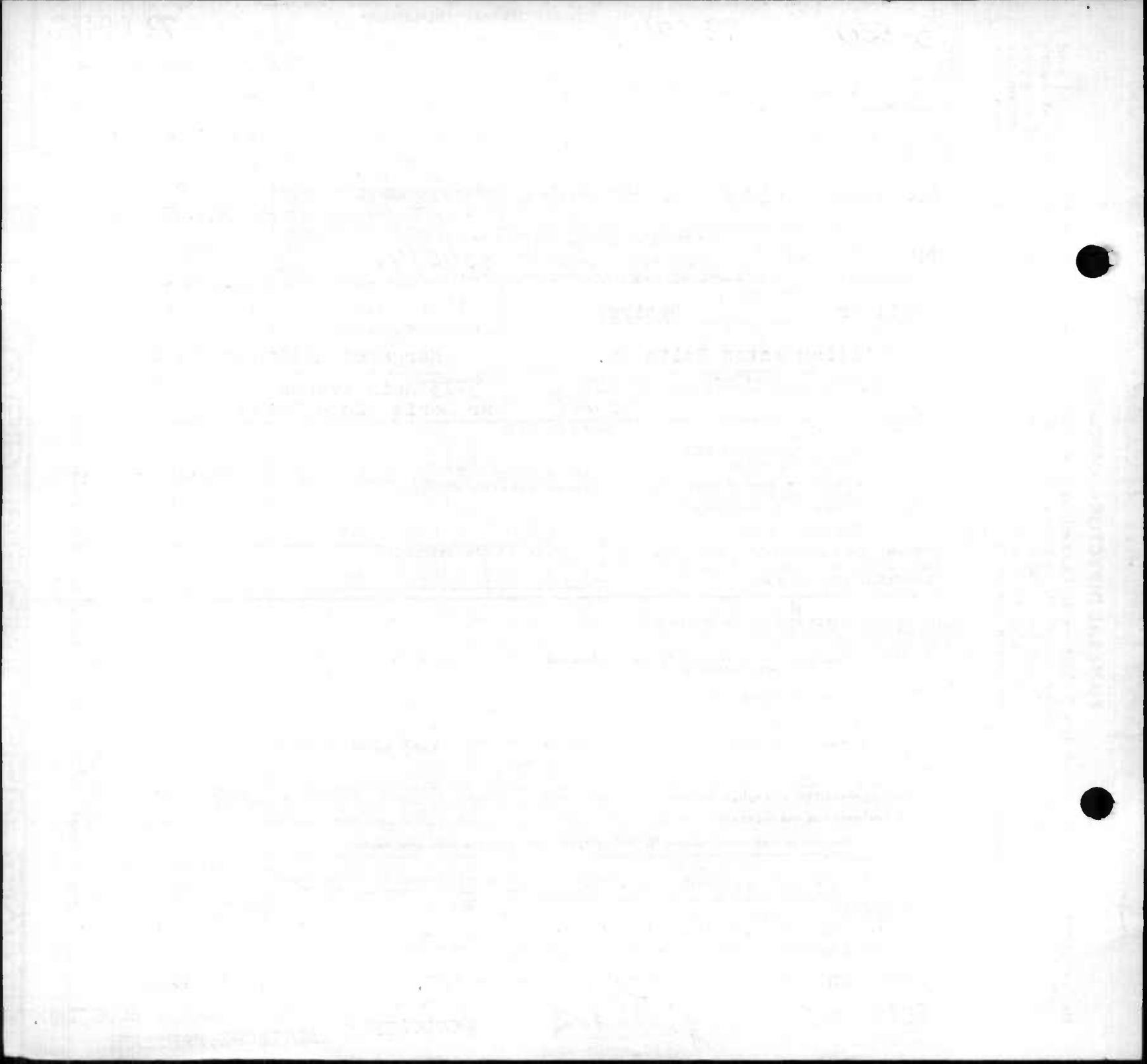
M-625		72 09486		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09486	
BIRTH NO.				STATE OF MARYLAND - DISTRICT			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
JOSEPH MORGAN				10-01-72 5:55 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
3 THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205				MARYLAND			
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				2126 MARYLAND AVE			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 Yr. Months: Days	11. UNDER 24 Hrs. Hours: Min.	12. CITIZEN OF WHAT COUNTRY?
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	01-12-93	79			U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Salesman		retired		Waterbury, Connecticut		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Morgan				?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
Yes World War I		212-22-0854		Ernest Scholtz-Rt2, Box 322, Severna Park			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				3 days			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
				Gram negative sepsis with shock			
ANTECEDENT CAUSES				(B) EMPYEMA OF GALLBLADDER			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO, OR AS A CONSEQUENCE OF:			
				> 1 month			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Acute renal failure			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
19-21-72		Empyema of gallbladder		NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (1) (this hospital) attended the deceased from October 1 1972 to October 1 1972, that (1) (we) last saw the deceased alive on October 1 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Frederick W. Walker, M.D.				October 1, 1972			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
FREDERICK W. WALKER				The Johns Hopkins Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		Oct. 4, 72		Gettysburg National		Gettysburg, Penna.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
OCT 5 1972		Sidney H. Sander		H. Sander & Sons, Inc., Balto., Md.			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		72 09487		REG. NO.		72 09487	
1. NAME OF DECEASED (Type or Print) <b>WILLIAM A. SMITH Jr.</b>				2. DATE AND HOUR OF DEATH <b>10-3-72 5:30 A.M.</b>		STATE OF MARYLAND - DISTRICT			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>MARYLAND GENERAL HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> , B. COUNTY <b>Baltimore</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>M</b> 6. RACE <b>W</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>03/15/96</b> 9. AGE (in years last birthday) <b>76</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Builder</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>William Anton Smith SR.</b>			
14. MOTHER'S MAIDEN NAME <b>Margaret Elleanor Hiltz</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213 48 2085</b>		17. INFORMANT <b>Mr Doris Blome Smith</b> ADDRESS <b>3915 Main Avenue</b>	
18. <b>153.01</b> CAUSE OF DEATH				DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Intracranial Hypertension</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 month</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Cerebral metastases</b>				(B) DUE TO, OR AS A CONSEQUENCE OF: <b>AdenoCa of Cecum.</b>		<b>2 month.</b>		<b>2 years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>August 14 1972</b> to <b>Oct. 3 1972</b> that (I) (we) last saw the deceased alive on <b>Oct 3 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Medinilla MD</b>				23B. DATE SIGNED <b>10-3-72</b>					
23C. PHYSICIAN'S NAME (Type) <b>OTTO R. MEDINILLA MD.</b>				23D. ADDRESS <b>827 Linden Ave. Balto. Md. 21201</b>					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>10/5/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Security Process INC.</b>		24D. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		(State)	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 5 1972</b>		25B. NAME OF REGISTRAR <b>Andrew Johnson</b>		25C. FUNERAL DIRECTOR <b>Henry Sander &amp; Sons Inc.</b>		ADDRESS <b>BALTIMORE, MARYLAND</b>			





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 09488

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>L. MICHAEL COLGAN</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>40 St. Agnes Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>10 1 1972 12:30p M.</b>	
6. SEX <b>male</b>		7. RACE <b>white</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>Feb. 28, 1958</b>		10. AGE (In years lost birthday) <b>14</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Irvin Hartman Colgan</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>	
15. MOTHER'S MAIDEN NAME <b>Elizabeth M. Sauerhoff</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO. <b>None</b>		18. INFORMANT ADDRESS <b>William H. Smith 5604 Braxfield Rd.</b>	
19. <b>E 928 IX</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>Traumatic asphyxia</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>road</b>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>Sulphur Spring Rd. Rt. 195</b>		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>10-1-72 12:10p m.</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Subj. crushed by crane.</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>R. S. Fisher</b> M.D. EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b> DATE SIGNED <b>10-2-72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>10/4/72</b>	
24C. NAME of CEMETERY or CREMATORY <b>Loudon Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 5 1972</b>		25B. NAME OF REGISTRAR <b>Edw. S. MacNabb Sons, Inc.</b>	
25C. FUNERAL DIRECTOR <b>Edw. S. MacNabb Sons, Inc.</b>		ADDRESS <b>Catonsville, Md.</b>	



Feb. 20, 1953

Baltimore, Maryland

USA

Irvin Harrison Colgan

Elizabeth M. Harnisch

Student

No

Name

William H. Allen 5604 Strickland Rd.

Transmittal Receipt

William H. Allen, Jr.

2 copies, enclosed in envelope.

Bureau 100-4772

London Field

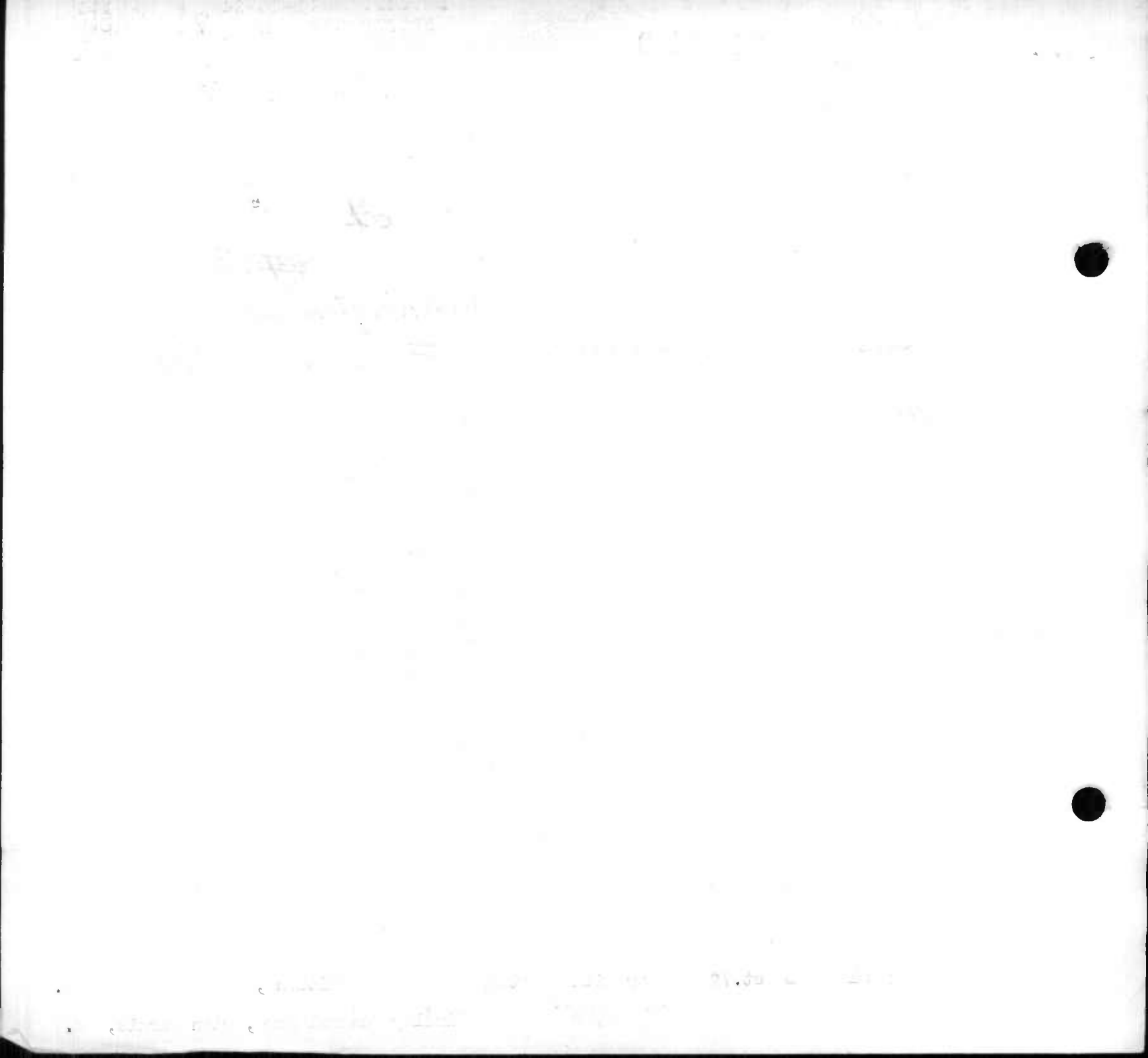
Baltimore, Maryland

W. H. Allen, Jr.  
Crownsville, Md.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-620		72 09489		BALTIMORE CITY HEALTH DEPARTMENT CITY OF BALTIMORE		REG. NO. 72 09489		STATE OF MARYLAND - DEPT. OF HEALTH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>EVELYN P Ayers</b>				2. DATE AND HOUR OF DEATH <b>130 AM 3 Oct 72</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIV. OF MARYLAND HOSP</b> <b>38</b>						A. STATE <b>MD</b>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)						C. CITY OR TOWN <b>SOLOMONS IS</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
						E. STREET AND NUMBER <b>Box 64</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/25/08</b>		9. AGE (In years last birthday) <b>63</b>		If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>Washington DC,</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thompson, Alonzo B.</b>				14. MOTHER'S MAIDEN NAME <b>EVA E. TAYLOR</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>CHART</b>			
18. CAUSE OF DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>156.01</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						(A) IMMEDIATE CAUSE <b>RESPIRATORY FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF:			
						(B) <b>GENERALIZED METASTASES</b> DUE TO, OR AS A CONSEQUENCE OF:			
						(C) <b>CARCINOMA OF GALLBLADDER</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <b>May 72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>RUG MAN</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>10/2</b> 19 <b>72</b> to <b>10/3</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>10/2</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Edmund C Tortolani, MD</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>3 Oct 72</b>			
23C. PHYSICIAN'S NAME (Type) <b>TORTOLANI EDMUNDO</b>				23D. ADDRESS <b>UNIV MARYLAND HOSP</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6 Oct. 72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Cedar Hill Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Suitland, Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>OCT 5 1972</b>		25B. NAME OF REGISTRAR <b>Andrew H. ...</b>		25C. FUNERAL DIRECTOR <b>Kirkley Funeral Home, Glen Burnie, Md.</b>					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 09490		BALTIMORE CITY HEALTH DEPARTMENT		72 09490	
STATE OF MARYLAND - DEPT. OF HEALTH					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <i>Mrs. Elizabeth Raleigh</i>			2. DATE AND HOUR OF DEATH <i>10/4/72 - 8:40 a.m.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Edgewood Nursing Home</i>			A. STATE <i>Md.</i>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			B. COUNTY		
C. CITY OR TOWN <i>Baltimore</i>			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <i>6201 Loch Raven Blvd.</i>			<i>21212</i>		
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-18-1906</i>	9. AGE (In years lost birthday) <i>66</i>	10. If Under 1 Mo. 1 Yr. 1 Hr. 1 Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Secretary Md. Geological Survey</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Balto., Md.</i>	
13. FATHER'S NAME <i>Fred Bonhage</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth G. Hammond</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-03-6500D</i>		17. INFORMANT <i>Mr. Frederick W. Bonhage</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Extensive metastatic spread</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 yr.</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Grave anemia</i>		<i>1 yr.</i>	
		(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Hodgkin's granuloma</i>		<i>2 yrs.</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <i>1/29</i> <i>1967</i> to <i>10/4</i> <i>1972</i> that (1) (we) last saw the deceased alive on <i>9/29</i> <i>1972</i> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>H. Margret Zassenhaus, M.D.</i>				23B. DATE SIGNED <i>10/4/72</i>	
23C. PHYSICIAN'S NAME (Type) <i>H. MARGRET ZASSENHAUS, M.D.</i>				23D. ADDRESS <i>7028 BELLONA AVE, BALTIMORE MD. 21212</i>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>10-6-72</i>		24C. NAME OF CEMETERY or CREMATORY <i>Baltimore National</i>	
<i>Burial</i>		<i>10-6-72</i>		<i>Balto.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>OCT 5 1972</i>		25B. NAME OF REGISTRAR <i>Sidney Johnston</i>		25C. FUNERAL DIRECTOR <i>H. W. Jenkins &amp; Sons Co.</i>	
				ADDRESS <i>1905 York Road Balto., Md. 21212</i>	

Benjamin Franklin  
A. D. Clark Jr.  
of one

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 09491

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Justin Rogers		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 10 Day 1 Year 72 Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 University Hospital		3. DATE PRONOUNCED DEAD Month 10 Day 1 Year 72 Hour 2:10 a. M.	
6. SEX male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY Harford	
9. DATE OF BIRTH May 7, 1951		10. AGE (In years last birthday) 21	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles B. Rogers		14. MOTHER'S MAIDEN NAME Pauline E. Clark	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		18. SOCIAL SECURITY NO.	
19. E 812.0		19. CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		Multiple injuries	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Highway	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? St. Rte. 165 - 1500 ft. south of Born Road		22D. TIME OF INJURY (APPROX.) Month 10 Day 1 Year 72 Hour 12:30 a.m.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subject driver in two car collision.	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 10/1/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Oct. 5, 1972	
24C. NAME OF CEMETERY or CREMATORY Bel Air Memorial Gardens		24D. LOCATION (City, town, or county) (State) Bel Air, Harford Co., Md	
25A. DATE REC'D BY HEALTH DEPT. OCT 5 1972		25B. NAME OF REGISTRAR Sidney W. Harkins	
25C. FUNERAL DIRECTOR John H. Harkins		ADDRESS Delta, Pa.	

25 10101

25 10101

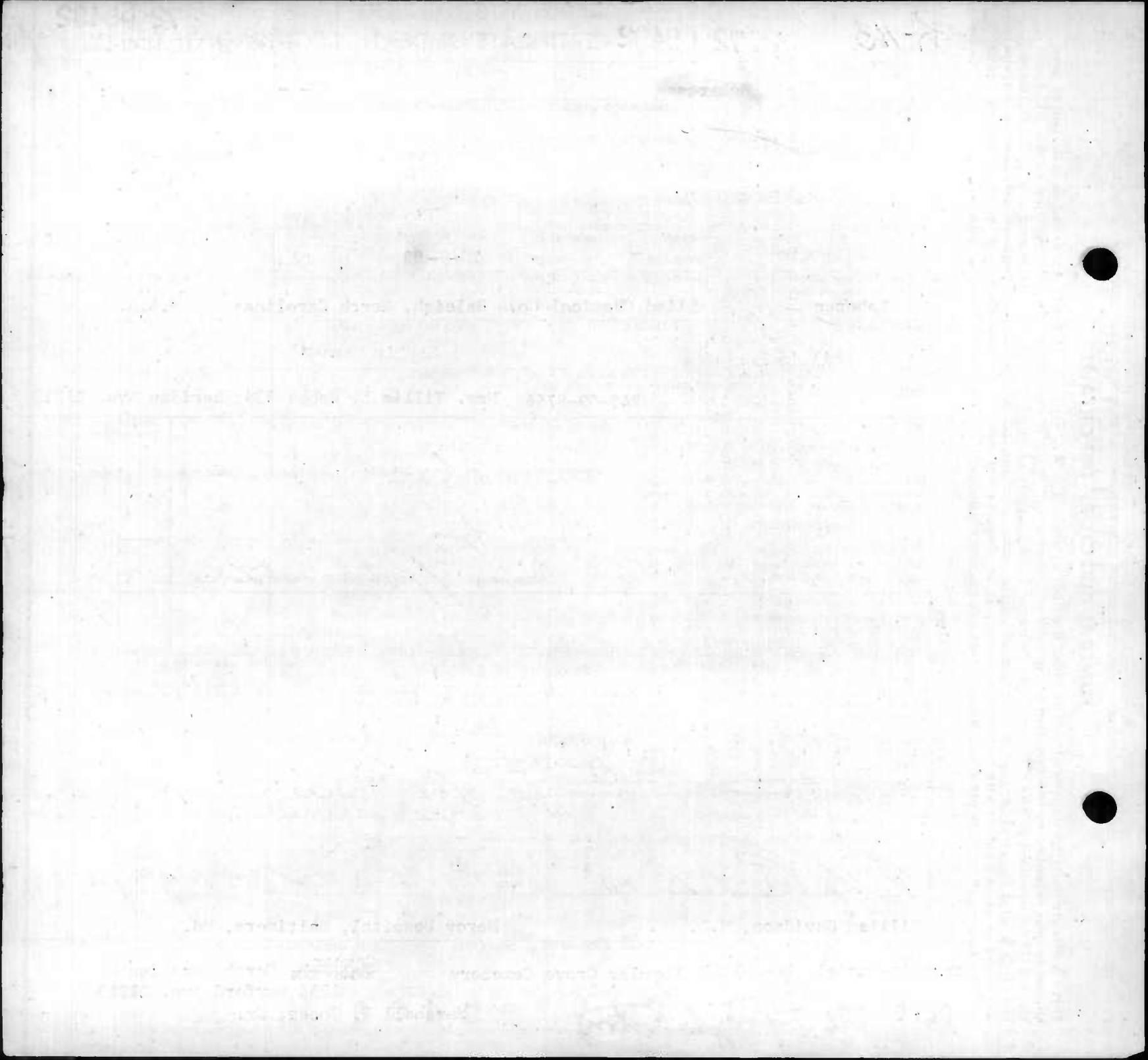
*Handwritten signature*



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 09492		72 09492	
BIRTH NO. <u>R-163</u>				72 09492		72 09492	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Floyd Robertson				10-4-72 9:10 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE Md		B. COUNTY	
37 MERCY HOSPITAL				C. CITY OR TOWN Balto		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 538 Sheridan Ave							
5. SEX M	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-9-09	9. AGE (In years last birthday) 62	If Under 1 Yr. Months: Days	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Allied Chemical Co.		11. BIRTHPLACE (State or foreign country) Raleigh, North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Willie Robinson				14. MOTHER'S MAIDEN NAME Sophia Cheeks			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 243-03-8756		17. INFORMANT ADDRESS Mrs. Tillie L. Hobbs 538 Sheridan Ave. 21212			
18. <u>185X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Subarachnoid hemorrhage</u> (B) <u>Senile</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Arteriosclerosis of cerebral arteries</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>72 yrs</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>9/28</u> 19 <u>72</u> to <u>10/4</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>10/4</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>William B. Davidson MD</u>				23B. DATE SIGNED <u>10/4/72</u>			
23C. PHYSICIAN'S NAME (Type) William Davidson, M.D.				23D. ADDRESS Mercy Hospital, Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) transit-burial		24B. DATE 10-7-1972		24C. NAME OF CEMETERY OR CREMATORY Popular Grove Cemetery		24D. LOCATION (City, town, or county) (State) Raleigh, North Carolina	
25A. DATE REC'D BY HEALTH DEPT. OCT 6 1972		25B. NAME OF REGISTRAR <u>Sidney Robinson</u>		25C. FUNERAL DIRECTOR Marshall W. Jones, Jr.			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital, (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

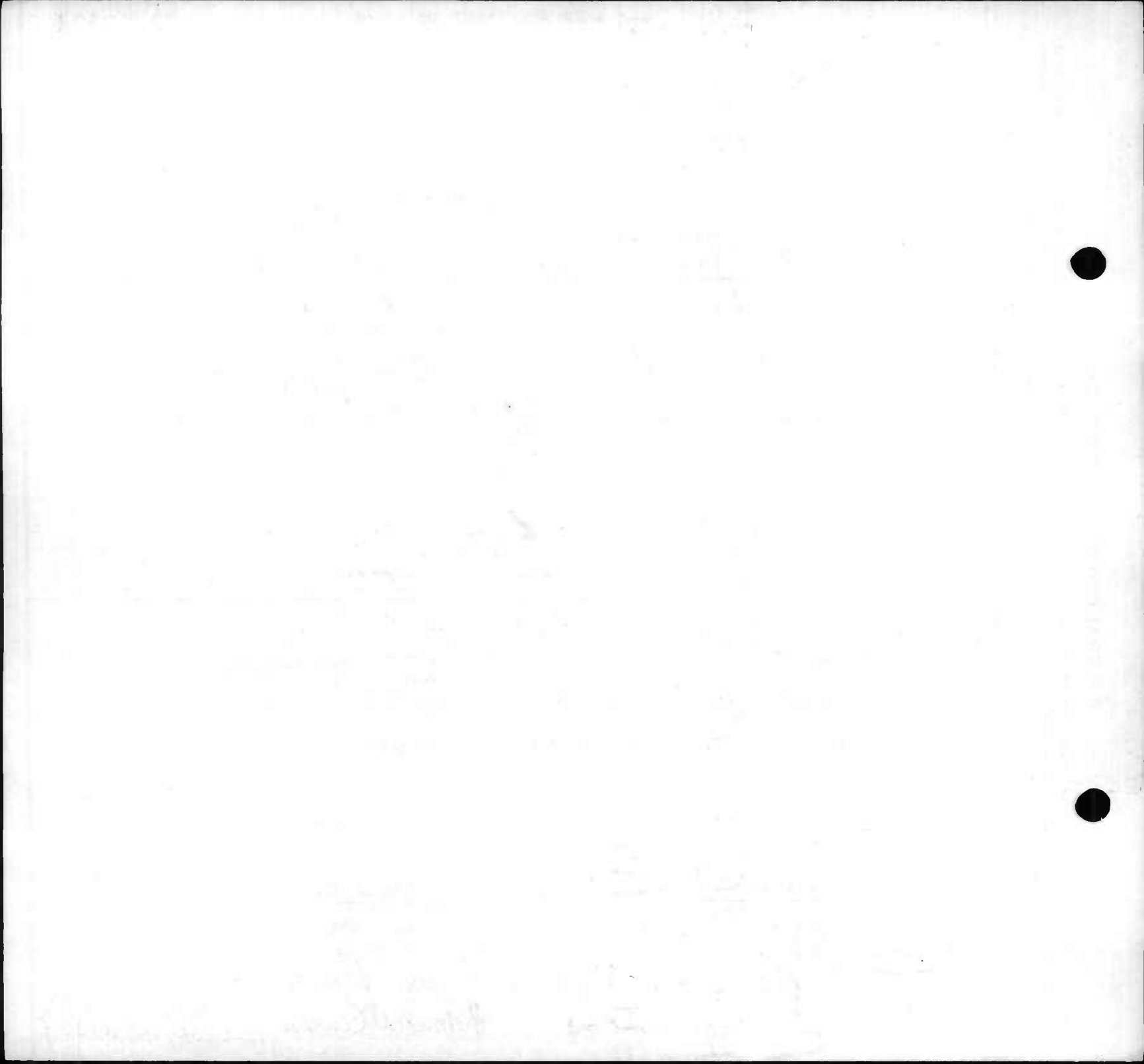
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 09493</u>	
<div style="display: flex; justify-content: space-between;"> <span><b>K-330</b></span> <span><b>72 09493</b></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
1. NAME OF DECEASED (Type or Print) <u>Baby Kennedy</u>		2. DATE AND HOUR OF DEATH <u>8/18/72</u> <u>10:30 AM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1512</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>39</u> <u>Provident Hospital, Inc.</u> <u>2600 Liberty Height Ave.</u> <u>Baltimore, Md. 21215</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Male</u>		6. RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>8-18-72</u>		9. AGE (in years last birthday) <u>42</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Linda Kennedy 3701 Park Height Ave.</u>	
18. CAUSE OF DEATH					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 50%;"> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardio Respiratory failure</u></p> <p>(B) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C)</p> </div> </div>					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
<div style="text-align: center;">II</div> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>August 18, 1972</u> to <u>August 18, 1972</u>		that (I) (we) last saw the deceased alive on <u>August 18, 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Manuel G. Mercado</u>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>MANUEL G. MERCADO</u>	
23D. ADDRESS <u>PROVIDENT HOSP. BALTO MD 21215</u>					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>10.3.72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>U of M Anatomy Bldg</u>	
24D. LOCATION (City, town, or county)		24E. STATE (State) <u>BALTO MD</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>OCT 6 1972</u>		25B. NAME OF REGISTRAR <u>Linda Kennedy</u>		25C. FUNERAL DIRECTOR <u>Raymond J. Curran</u>	

# 9. Born at 9:48 A.M.  
Expired at 10:30 A.M.  
OT

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-530		72 09494		BALTIMORE CITY HEALTH DEPARTMENT		72 09494	
BIRTH NO.		CERTIFICATE OF DEATH				REG. NO.	
1. NAME OF DECEASED (Type or Print)		SMITH, ROBERT H.		2. DATE AND HOUR OF DEATH		10-4-72 1:20 A.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Maryland		1401	
+ The Union Memorial Hospital				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				150 P Bolton St.			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 Yr. Months	11. UNDER 24 Hrs. Days	12. UNDER 24 Hrs. Hours
M.	W.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	07-19-05	67			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Home Visitor				Arkansas		American	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
Ector Smith.		Harriet Henry.		Unknown		BSEC-408-05-1564 Plan B IND.	
17. (INFORMANT)		ADDRESS		18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
JESSE RECORDS				Disease or condition directly leading to death		5 Min.	
				(A) IMMEDIATE CAUSE			
				DUE TO, OR AS A CONSEQUENCE OF:			
				(B) Metastatic Adeno Carcinoma		6 Months.	
				DUE TO, OR AS A CONSEQUENCE OF:			
				poorly differentiated.			
				(C)			
				Diabetes Mellitus.			
19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 9-12-1972 to 10-4-1972 that (I) (we) lost saw the deceased alive on 10-4-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
Dante Mangari M.D.		10-04-72		Dante Mangari M.D.		Union Memorial Hospital.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
REMOVAL		10-3-72		UOFM ANATOMY BOARD		BALTIMORE, MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS	
OCT 6 1972		Sidney Johnston		Raymond Curran		517 SCARLETT DR. TOWSON, MD 21204	



# FUNERAL DIRECTOR: IMPORTANT

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J-000		72 09495		BALTIMORE CITY HEALTH DEPARTMENT		72 09495	
BIRTH NO. 72-14602		CERTIFICATE OF DEATH		REG. NO. 72 09495		STATE OF MARYLAND	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
JAY, BABY GIRL		OCTOBER 3, 1972 11:30A M.		FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL		A. STATE MARYLAND B. COUNTY BALTIMORE	
5. SEX FEMALE		6. RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/02/72	
9. AGE (In years last birthday) 12		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NEW BORN		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RICK JAY		14. MOTHER'S MAIDEN NAME MARYNETTE DUNSHEE JAY		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS		18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ST. AGNES HOSPITAL RECORDS				DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ATELECTASIS OF LUNGS 12 hours			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		ANTECEDENT CAUSES		EMPHYSEMA OF MEDIASTINUM			
POLYCYSTIC KIDNEYS		PNEUMOTHORAX (BILATERAL) for first 6 hours					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from OCTOBER 02 1972 to OCTOBER 03 1972		that (I) (we) last saw the deceased alive on OCTOBER 03 1972		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
AZAD CADER		OCTOBER 4 1972		AZAD CADER		BALTIMORE, MD 21229	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		10/5/72		Meadowridge Cemetery		Dorsey, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
OCT 6 1972		L. J. H. H. H.		Witzke, 1630 Edmondson Avenue		21228	



11:30

OCTOBER 2, 1972

ALL DAY GIRL

ST. JAMES

ST. JAMES

ST. JAMES HOSPITAL

ST. JAMES HOSPITAL

ST. JAMES

ST. JAMES HOSPITAL

ST. JAMES

ST. JAMES

ST. JAMES HOSPITAL

ST. JAMES

ST. JAMES HOSPITAL

OCTOBER 2

OCTOBER 2

OCTOBER 2

OCTOBER 2

OCTOBER 2

OCTOBER 2

FUNERAL DIRECTOR: IMPORTANT

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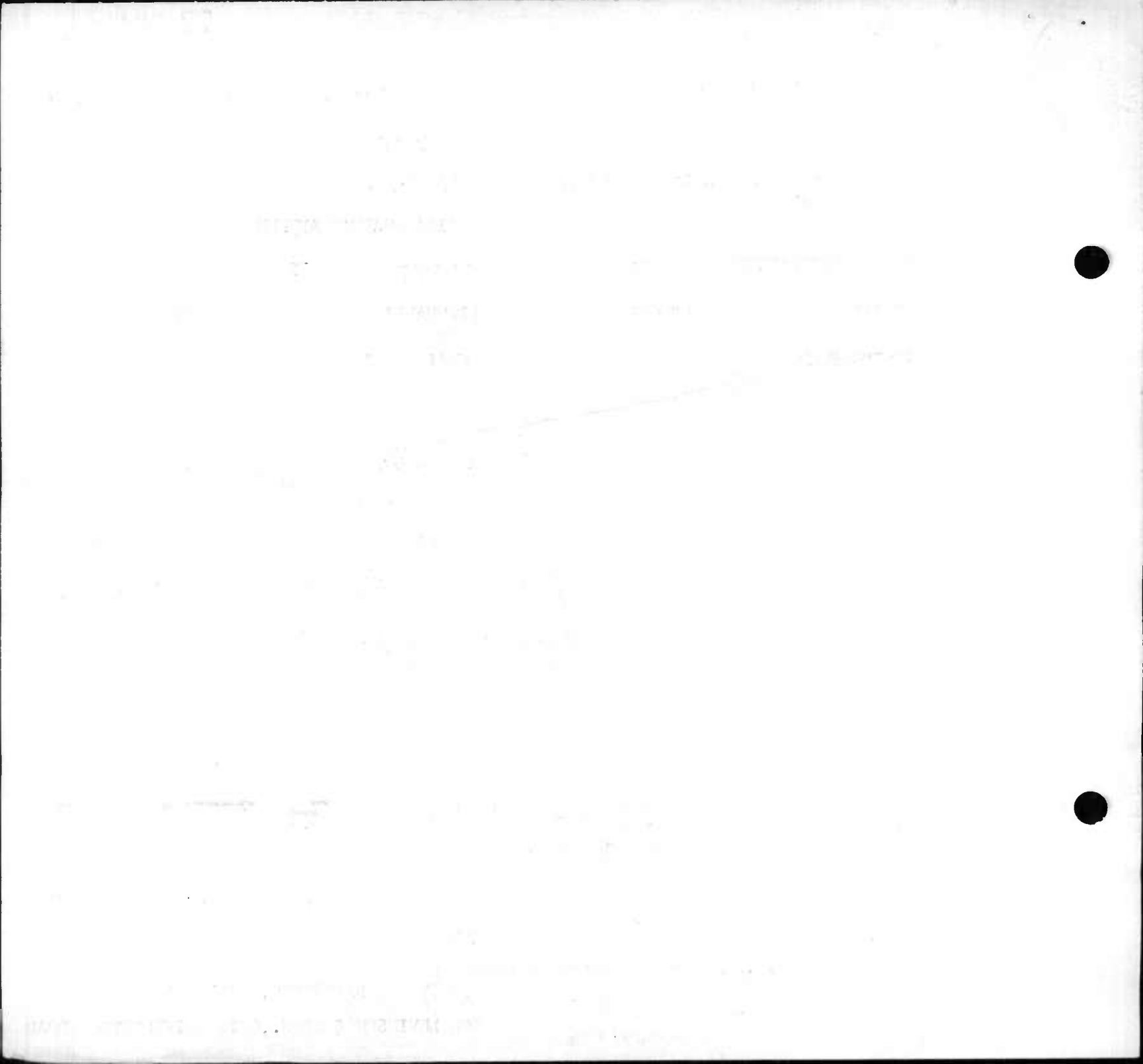
B-653		72 09496		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09496	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
BURNETTE, MARGARET G.				10-3-72 4:00 Pm			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
Bon Secours Hosp.				Maryland 2531			
5. SEX				6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
F		W		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
						7-27-88	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)	
						84	
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
North Carolina				U.S.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Jesse Gaye				Lora Tendor			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				217-01-4791		Mrs. Dorothy Hepner 4907 Stafford St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,				(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-22-72 19 to 10-3-72 19 that (I) (we) last saw the deceased alive on 10-3-72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. d. Pm				23A. SIGNATURE			
23B. DATE SIGNED				23C. PHYSICIAN'S NAME (Type)			
23D. ADDRESS				23E. FUNERAL DIRECTOR			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial				10/7/72		Forest Hill Cemetery	
24D. LOCATION (City, town, or county) (State)				24E. DATE REC'D BY HEALTH DEPT.			
Farmville, N. C.				OCT 6 1972			
25A. NAME OF REGISTRAR				25B. ADDRESS			
Witzke				1630 Edmondson Ave			



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				72 09497		REG. NO.	
BIRTH NO.				72 09497		STATE OF MARYLAND - DEATH	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
MORRIS BONN				October 3, 1972		11:15 A.M.	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE B. COUNTY		5. CITY OR TOWN D. INSIDE CITY LIMITS?	
LEVINDALE HEBREW GERIATRIC CENTER 91 AND HOSPITAL				MARYLAND BALTIMORE		YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER				6. DATE OF BIRTH		9. AGE (In years last birthday)	
4114 BOARMAN AVENUE				6-15-1897		75	
5. SEX MALE		6. RACE XXXX WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
RETAIL		GROCER		LITHUANIA		USA	
13. FATHER'S NAME JOSEPH BONN				14. MOTHER'S MAIDEN NAME CHAI ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Arteriosclerotic heart disease with shock</i> (B) <i>Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Pulmonary fibrosis</i> <i>Diabetes mellitus</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i> <i>one month</i> <i>many years</i> <i>years</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (X) (this hospital) attended the deceased from <u>6-15</u> 19 <u>60</u> to <u>October 3</u> 19 <u>72</u> that (X) (we) last saw the deceased alive on <u>October 3</u> 19 <u>72</u> and that (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.		23A. SIGNATURE <i>Soonchul Hong</i> 23C. PHYSICIAN'S NAME (Type) SOON CHUL HONG	
23B. DATE SIGNED October 3, 1972		23D. ADDRESS LEVINDALE		23E. FUNDING DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		23F. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10/4/1972		24C. NAME of CEMETERY or CREMATORY HEBREW ORTHODOX MEMORIAL SOCIETY		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. OCT 6 1972		25B. NAME OF REGISTRAR <i>Lidney Johnston</i>		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		25D. ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

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<div style="display: flex; justify-content: space-between;"> <span>S-350</span> <span>72 09498</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		<div style="display: flex; justify-content: space-between;"> <span>72 09498</span> <span>REG. NO.</span> </div> <h3 style="text-align: center;">STATE OF MARYLAND-DHMH</h3>	
BIRTH NO. <span style="float: right;">1</span> 1. NAME OF DECEASED (Type or Print) <span style="float: right;">2. DATE AND HOUR OF DEATH</span> <div style="display: flex; justify-content: space-between;"> <span>SAMUEL STEIN</span> <div>                     OCTOBER 3, 1972                      3:15 A.M.                 </div> </div>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  SHEFFIELD HOUSE, APT. 4B 6000 PARK HEIGHTS AVENUE		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="float: right;">B. COUNTY</span> MARYLAND <span style="float: right;">2720</span> C. CITY OR TOWN <span style="float: right;">D. INSIDE CITY LIMITS?</span> BALTIMORE <span style="float: right;">YES <input type="checkbox"/> NO <input type="checkbox"/></span> E. STREET AND NUMBER 6000 PARK HEIGHTS AVENUE, APT. 4 B	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 5, 1893
9. AGE (In years last birthday) 78		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PROPRIETOR	
11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-12-4387A	
17. INFORMANT MRS. REBA STEIN, 6000 PARK HIGHTS, AVE. #21215		ADDRESS SHEFFIELD HOUSE, APT. 4 B	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 15 yrs	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Nov 1963</u> to <u>Present</u> 19 <u>72</u> and that (I) (we) last saw the deceased alive on <u>9/28</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE 		23B. DATE SIGNED 10/3/72	
23C. PHYSICIAN'S NAME (Type) JOSEPH SHEAR		23D. ADDRESS 6715 PARK HEIGHTS AVENUE	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10-4-72	
24C. NAME OF CEMETERY or CREMATORY BETH TFILOH		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. OCT 6 1972		25B. NAME OF REGISTRAR 	
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		ADDRESS	





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K-413		72 09499		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 09499	
BIRTH NO.		72 09499		CERTIFICATE OF DEATH		STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print) SAUL KLUPT				2. DATE AND HOUR OF DEATH 10-3-72 3 45 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2740			
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL 33				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3410 DEVONSHIRE DR.			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-20-92	9. AGE (In years last birthday) 80	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRESSER		10B. KIND OF BUSINESS OR INDUSTRY SHOP		11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME <del>XXXXXXXXXXXX</del> UNKNOWN		14. MOTHER'S MAIDEN NAME <del>XXXXXXXXXXXX</del> UNKNOWN					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-07-2930		17. INFORMANT ADDRESS MRS. ESTHER KLUPT, 3410 DEVONSHIRE DR. #21215			
18. 038.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF: (B) SEPTICEMIA DUE TO, OR AS A CONSEQUENCE OF: (C) 1 WEEK		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Sept 19 1972 to Oct 3 1972, that (I) (we) last saw the deceased alive on Oct 3 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE C. Kent Osborne M.D.				23B. DATE SIGNED 10-3-72			
23C. PHYSICIAN'S NAME (Type) C. KENT OSBORNE M.D.				23D. ADDRESS JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10/4/1972		24C. NAME of CEMETERY or CREMATORY LAZER RISA SKLAR (FORBAND)		24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. OCT 6 1972		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR SOL LEVINSON		ADDRESS & BROS., 6010 REISTERSTOWN ROAD	

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FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 09500	
72 09500				STATE OF MARYLAND - DHMH	
BIRTH NO. 4-422		1. NAME OF DECEASED (Type or Print) HOLZWEIG, IDA			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH 10-3-72 6:22 A.M.			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY BALTIMORE			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN XXXXX BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
4-2		E. STREET AND NUMBER 2304 XXXXXX XXXXXXXXXXXX GERARD CT. #21209			
5. SEX Female	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH XXXXXXXXXX	9. AGE (In years lost birthday) 71	10. Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) LITHUANIA	
13. FATHER'S NAME SHIMIN SODDEN		12. CITIZEN OF WHAT COUNTRY? USA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. 216-28-1152		17. INFORMANT ADDRESS MRS. SONYA DAVIS, 8201 MAXINE CIRCLE, #21208	
18. 450X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiorespiratory arrest			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: Acute Myocardial Infarction			
		(C) Pulmonary emboli			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1/2 hr			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 9-30-1972 to 10-3-1972 that (2) (we) last saw the deceased alive on 10-3-1972 and that (3) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE K. MICHAELIDES MD		23B. DATE SIGNED 10-3-72		23C. PHYSICIAN'S NAME (Type) K. MICHAELIDES MD	
23D. ADDRESS SINAI HOSPITAL		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			
24B. DATE 10/4/72		24C. NAME OF CEMETERY or CREMATORY MIKRO KODESH		24D. LOCATION (City, town, or county) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. OCT 6 1972		25B. NAME OF REGISTRAR Sidney H. Hooton		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	

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